

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01999

CERTIFICATE OF DEATH

01980

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN IL MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3119 Homewood Parkway		e. STATE Maryland		f. USUAL RESIDENCE (where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 36 Kensington d. STREET ADDRESS 3119 Homewood Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KOSMO		First J. AFFANASIEV		Last Feb. 10, 1962	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 1, 1897		9. AGE (In years last birthday) 64		10. IF UNDER 1 YEAR Months 3 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (County & State, or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? Naturalized		13. FATHER'S NAME Yakov Affanasiev		14. MOTHER'S MAIDEN NAME Xenia Sablin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Npne		17. INFORMANT Wife Lydia W. Affanasiev Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma with extensive liver metastasis DUE TO Conditions, if any, which gave rise to immediate cause (b) Primary Carcinoma of colon DUE TO (a), stating the underlying cause last. (c) 3 1/2 years INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from January 2, 1962 to Feb 10, 1962 that (I) (we) last saw the deceased alive on Feb 10, 1962 , and that death occurred at 2:30 PM , from the causes and on the date stated above.					
22. SIGNATURE Charles F. Geschickter M.D. 22a. PHYSICIAN'S NAME (Type) Charles F. Geschickter 22b. DATE SIGNED Feb. 10, 1962					
22c. ADDRESS 1834 Conn. Ave., N.W., Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation					
23b. DATE THEREOF 2-12-62					
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory					
23d. LOCATION (City, town or county) (State) Suitland, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Md.					
25a. REC'D BY REGISTRAR FEB 14 '62					
25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01981

02029

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sen. & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> <input checked="" type="checkbox"/> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <u>47X-3</u> d. STREET ADDRESS <u>2 Pinehurst Circle N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Andrew Julius Altman</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-23-85</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Govt Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>NATURALIZED America-USA</u>							
13. FATHER'S NAME <u>Eustav Altman</u>				14. MOTHER'S MAIDEN NAME <u>Dorothea Lipholtz</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Wife</u> <u>Sara Jane Altman</u> Address <u>Same as Item 2.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO (b) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Valvular Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia and Kidney Shut down</u>																INTERVAL BETWEEN ONSET AND DEATH <u>One week</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)																			
21. I certify that (I) (this hospital) attended the deceased from <u>1-29</u> , 19 <u>62</u> to <u>2-5</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>2-5</u> , 19 <u>62</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>Stuart L. Nelson</u>										ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-5-62</u>			
22c. PHYSICIAN'S NAME (Type) STUART L. NELSON										22d. ADDRESS <u>7600 Carroll Ave., Takoma Park, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-8-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Montgomery County, Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>										ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 9 1962</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02001

CERTIFICATE OF DEATH

01982

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5721 Grosvenor Lane Resnor Sanitarium				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE -- b. COUNTY -- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC 47X-3 d. STREET ADDRESS 6674 32nd Street, N.W. e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Ira S Barker		4. DATE OF DEATH Feb 17 1962		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/16/1875		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86		IF UNDER 24 HRS. Hours 86 Min. 86			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-- U.S. Government				10b. KIND OF BUSINESS OR INDUSTRY Delaware				11. BIRTHPLACE (County & State, or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Q. Barker				14. MOTHER'S MAIDEN NAME Sally Collison				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no				17. INFORMANT Mrs. Betty B. Reed-- 6674 32nd Street, NW, Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL DUE TO (b) ARTERIOSCLEROSIS, CEREBRAL DUE TO (c) ARTERIOSCLEROSIS GENERALIZED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 1 Day 10 YRS 10 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
21a. TIME OF INJURY Hour 19 a.m. 19 p.m.				21b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				21d. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from JAN 10, 1962 to FEB 17, 1962, that (I) (we) last saw the deceased alive on FEB 17, 1962, and that death occurred at 11 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE Robert G. Angle M.D.								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED FEB 17, 1962							
22c. PHYSICIAN'S NAME (Type) Robert G. Angle								22d. ADDRESS 5009 Del Ray Avenue Bethesda 14, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/20/1962				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City, town or county) (State) Prince Georges County, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W. Washington 9, D.C.								25a. REC'D BY REGISTRAR DATE FEB 20 '62				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. #15ME
5M 9/60

02002 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 01983

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Silver Spring</u> d. STREET ADDRESS <u>1523 E. Falkland Lane</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Howard Calvin Barrett</u>				4. DATE OF DEATH <u>2 16 19 62</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-18-93</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Layer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shomper-Wells Co.</u>		9. AGE (In years last birthday) <u>68</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Harrisonburg, Virginia</u>	
13. FATHER'S NAME <u>Mr. Wm. H. Barrett</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I.</u>				16. SOCIAL SECURITY NO. <u>577-16-9380</u>		17. INFORMANT <u>Mrs. Ethel Barrett (wife)</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4+20 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>History of known heart disease</u> DUE TO (c) <u>Interval between onset and death</u> <u>sudden</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>History of known heart disease</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brochant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROCHANT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-16-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-19-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Prince George's Co. Maryland</u>	
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> <u>Warner E. Pumphrey, Inc.</u>				24a. REC'D BY REGISTRAR <u>FEB 21 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Pumphrey</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02003

CERTIFICATE OF DEATH

01984

Item 9 Film G308 2/28/62 iwk

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Maryland b. COUNTY St. Mary's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indianhead		d. STREET ADDRESS 6 Clermont St.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) James W. Bass				4. DATE OF DEATH Month Feb Day 20 Year 1962							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6/4/24					
9. AGE (In years last birthday) 37 1/2 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		11. BIRTHPLACE (County & State, or foreign country) North Carolina U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Walter Bass				14. MOTHER'S MAIDEN NAME Rachelle Coleman							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or dates of service) Naval war in Korea				16. SOCIAL SECURITY NO. Phyllis Bass / Jackson, Miss.							
17. INFORMATION Phyllis Bass / Jackson, Miss.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) 4204 PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary-arteriosclerotic h.d. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 27 hrs. 2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July 1960 to 2/20/62 , that (I) (we) last saw the deceased alive on 3/19/62 , and that death occurred at 3:25 PM , from the causes and on the date stated above.											
22a. SIGNATURE Edward J. Walsh				22b. DATE SIGNED 2/20/62		22c. PHYSICIAN'S NAME (Type) 1800 Eye St. N.E. Wash. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-24-62		23c. NAME OF CEMETERY OR CREMATORY Lakewood Mem. Ph Cem.		23d. LOCATION (City, town or county) (State) Jackson, Mississippi					
24. FUNERAL DIRECTOR'S SIGNATURE Paul Funeral Home				25a. REC'D BY REGISTRAR 4812 G St. Wash. D.C.		25b. REGISTRAR'S SIGNATURE Charles E. Kline					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

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For information
dated 10-1-42
Bureau of
Internal Security
Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

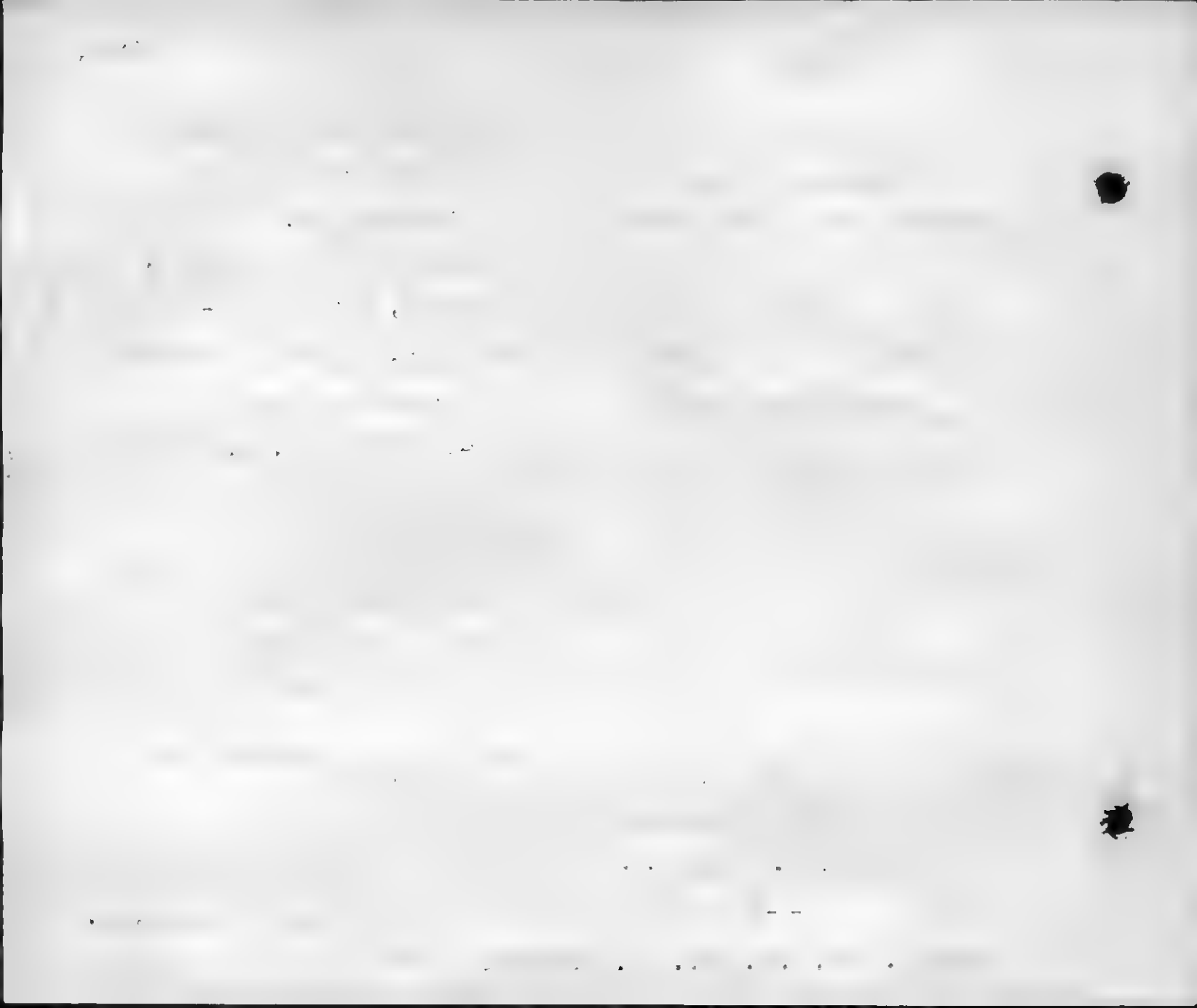
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01985

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>1100 Linden Ave., Apt 101</u>	
3. NAME OF DECEASED (Type or print) <u>Baumann</u>		4. DATE OF DEATH Last <u>February</u> 3, 19 <u>62</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 2, 1962</u>
9. AGE (In years last birthday) <u>0</u> yrs. <u>5</u> mos. <u>46</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Charles Bruce Baumann</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Mae Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>mother-1100 Linden Ave., Apt 101, Takoma Park, Md.</u>	
17. INFORMANT <u>Interval between onset and death</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Pulmonary tuberculosis</u> (b) <u>762.5</u> DUE TO <u>Pneumonia</u> (c) <u>762.5</u> DUE TO <u>Pulmonary tuberculosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... February 2, 1962 to February 3, 1962, that (I) (we) last saw the deceased alive on... February 3, 1962, and that death occurred at 6:20a from the causes and on the date stated above.			
22a. SIGNATURE <u>Winston E. Cochran</u>		22b. DATE SIGNED <u>2-3-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Winston E. Cochran, M.D.</u>		22d. ADDRESS <u>800 Reservoir Dr. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Cremation</u> <u>2-5-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Wash. San. & Hospital</u>		25a. REC'D BY REGISTRAR <u>FEB 8 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. DATE <u>FEB 8 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2075192162



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02005

CERTIFICATE OF DEATH

01986

1. PLACE OF DEATH COUNTY <u>Montgomery</u> CITY OR TOWN <u>Takoma Park</u> NAME OF HOSPITAL OR INSTITUTION <u>Washington Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY OR TOWN <u>Hyattsville</u> STREET ADDRESS <u>1904 Amherst Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Bernard Richard Bell</u>		4. DATE OF DEATH Year <u>1962</u> Month <u>2</u> Day <u>8</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-12-98</u>	
9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		10. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Isaac Bell</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Rowe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Navy WWI</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Elizabeth Bell - wife</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <u>Myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> to <u>Feb 8</u>, 19<u>62</u>, that (I) (we) last saw the deceased alive on <u>Feb 8</u>, 19<u>62</u>, and that death occurred at <u>2:45 PM</u>, from the causes and on the date stated above.			
22a. SIGNATURE <u>George Sharpe</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		22d. ADDRESS <u>10511 Summit Ave Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/12/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEM</u>		23d. LOCATION (City, town or county) (State) <u>ARL VA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.K. HUNTEMANN</u>		25a. REC'D BY REGISTRAR <u>13 '62</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. DATE <u>13 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr Broschart Contacted



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

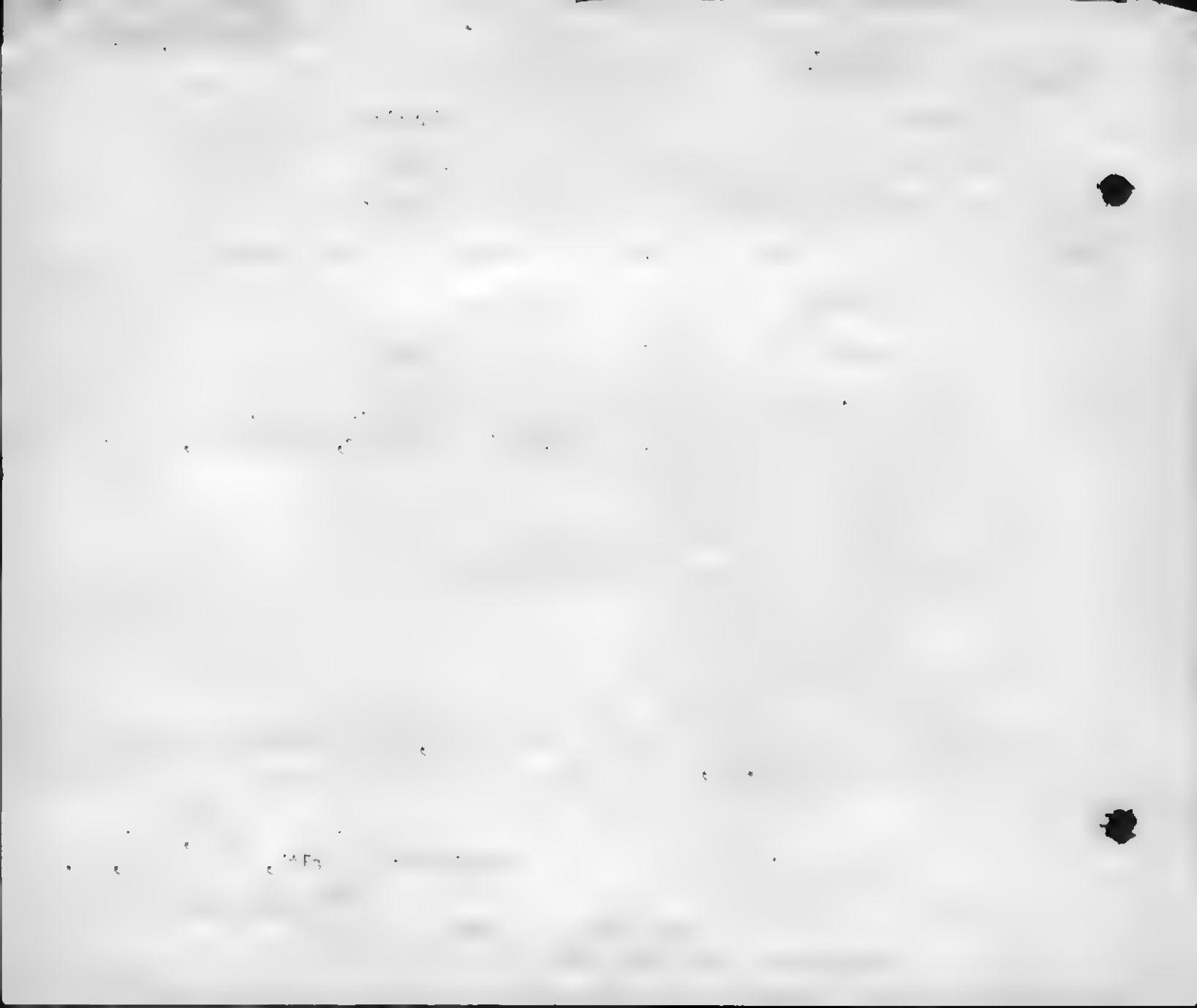
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02006

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01987

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 21 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Nebraska b. COUNTY Bertrand c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route # 2 d. STREET ADDRESS February 20, 1962	
3. NAME OF DECEASED (Type or print) EVONNE JEAN BENSON		4. DATE OF DEATH February 20, 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED		8. DATE OF BIRTH 9 July 1956	
9. AGE (In years last birthday) 5 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/> Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Child)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles L. Benson		14. MOTHER'S MAIDEN NAME Betty Fritz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		18. WHERE DECEASED The Clinical Center, Bethesda 14, Maryland	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 204.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Pseudomonas septicemia DUE TO (c) Acute lymphocytic leukemia		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (a) (this hospital) attended the deceased from January 30, 1962 to February 20, 1962 , that (b) (we) last saw the deceased alive on Feb. 20, 1962 , and that death occurred at 12:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Henderson M.D.		22b. DATE SIGNED February 20, 1962	
22c. PHYSICIAN'S NAME (Type) Edward S. Henderson, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/24/62	
23c. NAME OF CEMETERY OR CREMATORY W.W. Chambers Co. 1400 Chapin St NW Washington DC		23d. LOCATION (City, town or county) (State) Bertrand Nebraska	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		25a. REC'D BY REGISTRAR FEB 23 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Fries			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02007

CERTIFICATE OF DEATH

01989

Item 6 311M 6507 2/15/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>		d. STREET ADDRESS <u>5162-34th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Bernstein</u> Last <u>Bernstein</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>AM. Jewish</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/6/75</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u>3</u> Min <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Goldberg</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rubin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Mrs. Edna Schwartz</u> Address <u>5162, 34th St. N.W., Wash. D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the Breast</u>		(c) <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive and Arteriosclerotic Vascular Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 3</u> 19 <u>62</u> , to <u>FEB 4</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>FEB 3</u> 19 <u>62</u> , and that death occurred at <u>9:05</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert L. Krichmar</u> M.D.		22b. DATE SIGNED <u>FEB 4 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>		22d. ADDRESS <u>7733 ARASKA AVENUE NW WASH DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-6-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>YONAH SHOLOM-TALMUD TORAH CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY</u> ADDRESS <u>1506-3501-1413 ST NW</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01990

Reg. Dist. No.

02008

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7 TAKOMA PARK MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6807 ALLEGHENY ST.</u>		1. d. STREET ADDRESS <u>6807 ALLEGHENY ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Betz</u> Last <u>Betz</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM BETZ</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE BETZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>JOSEPH LAPIANA JR. ATTY.</u>		Address <u>1000 CONN. AVE. NW WASHINGTON, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) <u>arteriosclerosis & senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>3-5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>—</u> Year <u>—</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb-17, 1962</u> to <u>Feb-17, 1962</u> , that I last saw the deceased alive on <u>Feb-17, 1962</u> , and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sydney Leventhal, M.D.</u>		ADDRESS (Street, city or town, state) <u>9210 Coleridge Rd, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		DATE SIGNED <u>2/17/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>21 FEB 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ABBEY MAUSOLEUM</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u>		ADDRESS <u>7400 GEORGIA AVE NW</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>FEB 20 '62</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

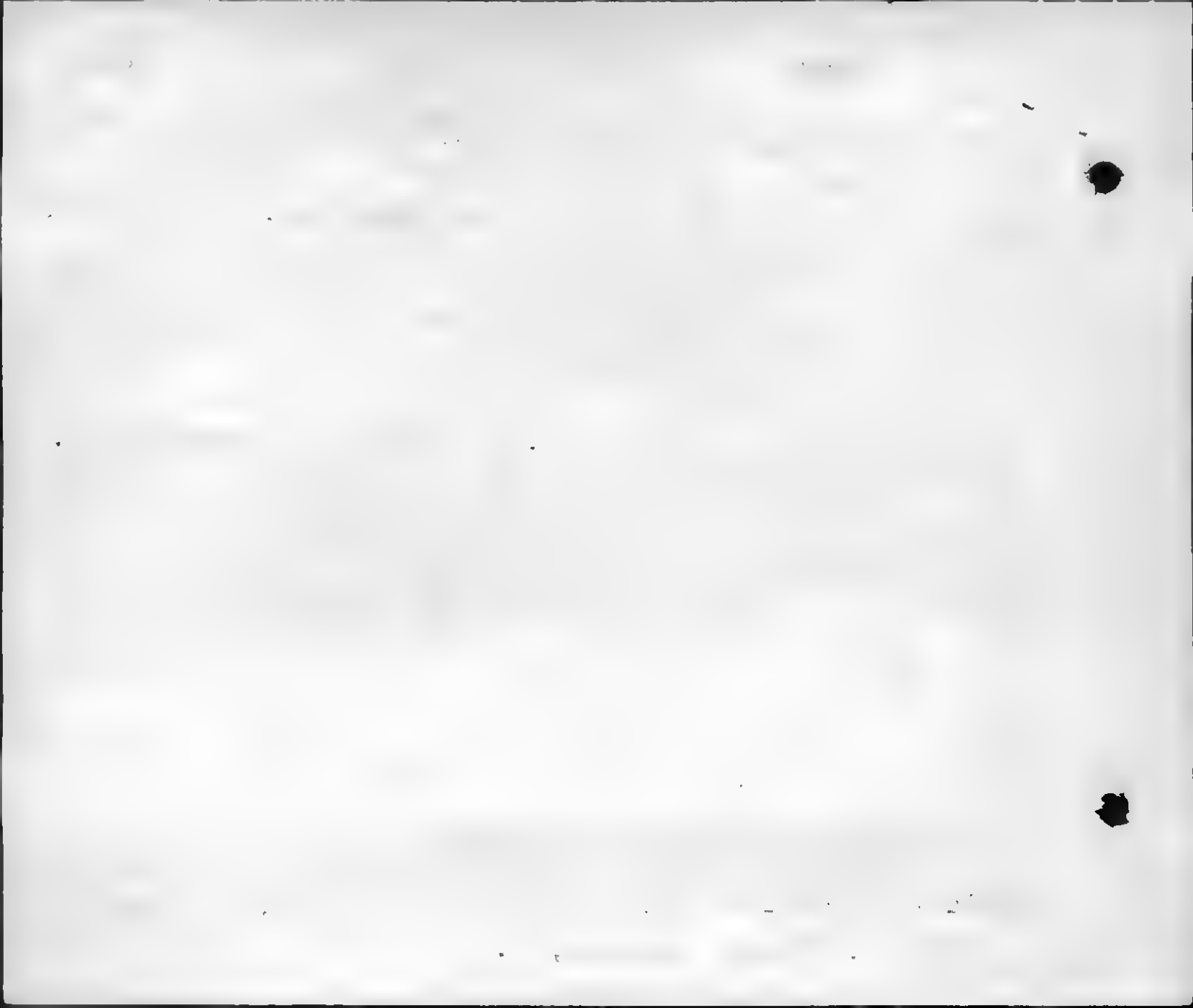
02009

CERTIFICATE OF DEATH

01991

Item 9 Film 4207 4/25/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>40</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. STREET ADDRESS <u>5526 Oakmont Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARTHA N. BLANKENSHIP</u>		4. DATE OF DEATH <u>Feb. 18 1962</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>27 Dec 1875</u>		9. AGE (In years last birthday) <u>87</u>		10. FUNDING YEAR Months <u>1</u> Days <u>18</u> Hours <u>62</u> M'n.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Comden Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William A. Ayers</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Hamilton Dougherty</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Beulah Lacey</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.5</u> DUE TO CIRCULATORY COLLAPSE ARTERIO SCLEROTIC HEART DISEASE GEN'L ARTERIO SCLEROSIS CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>PNEUMONIA & UREMIA</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>2+ HRS.</u> <u>5+ YRS.</u> <u>10+ YRS.</u>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>D.N.A.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>D.N.A.</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>62</u> , to <u>2/18</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>2/16</u> , 19 <u>62</u> , and that death occurred at <u>2:40</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>Charles J. Sawardest</u>		22b. PHYSICIAN'S NAME (Type) <u>CHARLES J. SAWARDEST, M.D.</u>		22c. ADDRESS <u>4890 BATTERY CANE BETHESDA, MD</u>		22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED <u>2/18/62</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		23b. DATE THEREOF <u>2-19-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wichita Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Wichita, Kansas</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		24a. ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>Feb 21 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

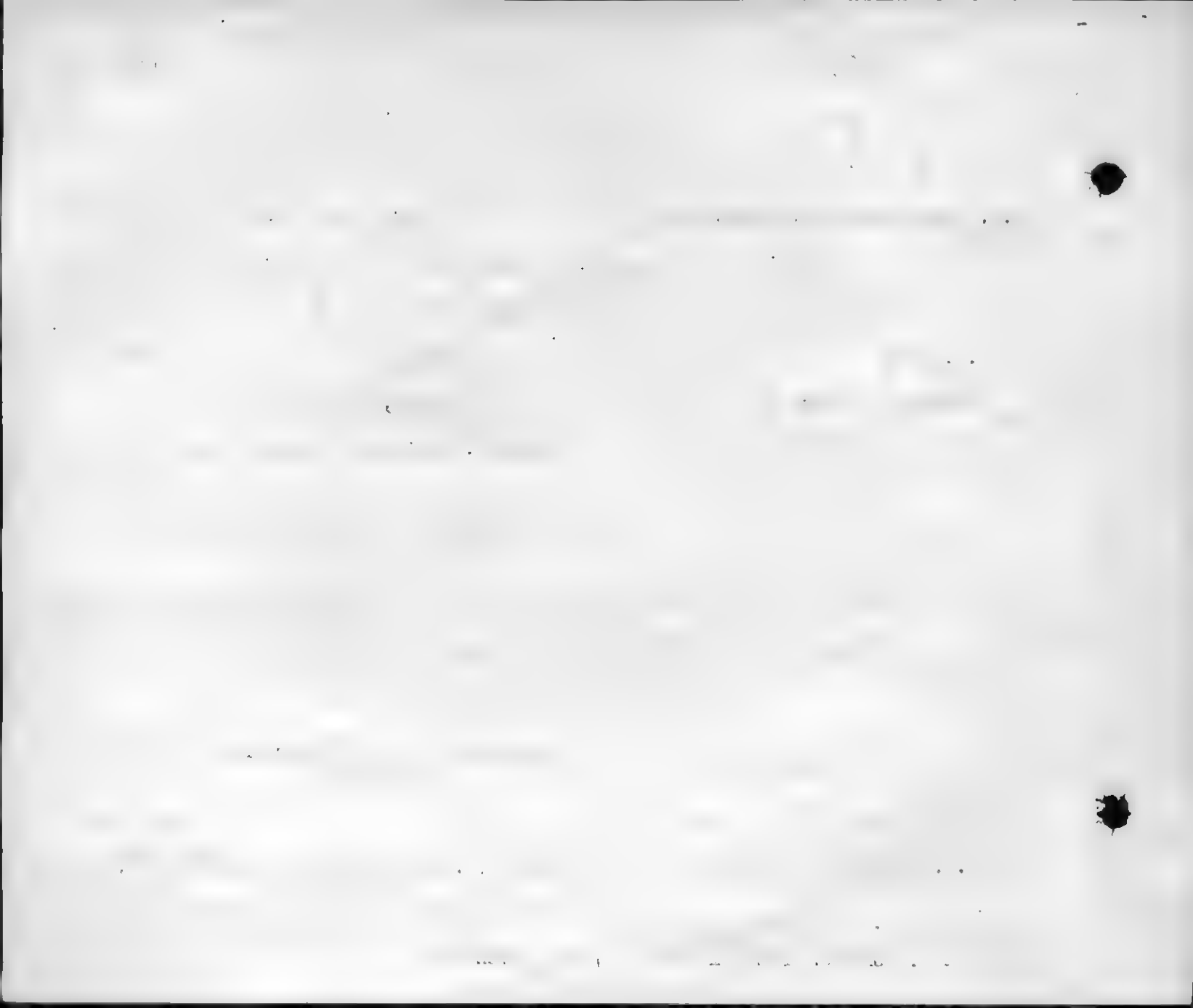
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02010

01992

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN b 9 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Ohio b. COUNTY Fremont c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 223 North Wood Street d. STREET ADDRESS 223 North Wood Street	
3. NAME OF DECEASED (Type or print) Emil Ignatius Bodenlos		4. DATE OF DEATH Month February Day 8 Year 1962	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 April 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BODENLOS, Robert I.		14. MOTHER'S MAIDEN NAME GEDEON, Charlotte	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		17. INFORMANT wife Mrs. Marie Al Bodenlos Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Heart Failure 4216 DUE TO Rheumatic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 31 January , 1962, to 18 February , 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8 February , 1962, and that death occurred at 2230 PM from the causes and on the date stated above.			
22a. SIGNATURE W.F. Warrender M.D. 22b. PHYSICIAN'S NAME (Type) W.F. WARRENDER LT MC. USN		22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U.S. NAVAL HOSPITAL BETHESDA, MD.	
22e. DATE SIGNED 9 Feb 1962			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-13-62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington Virginia		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. PUMPHREY 24a. ADDRESS Bethesda Maryland		25a. REC'D BY REGISTRAR FEB 13 '62	
25b. REGISTRAR'S SIGNATURE Robert A. PUMPHREY			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02011

01993

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halltown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS No street address	
3. NAME OF DECEASED (Type or print)	First William Middle Elwood Last Bowers	4. DATE OF DEATH	Month February Day 27 Year 19 62
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster	10b. KIND OF BUSINESS OR INDUSTRY Government	9. AGE (In years last birthday) 36 yrs.	11. BIRTHPLACE (County & State or foreign country) West Virginia
13. FATHER'S NAME Winerd Bowers	14. MOTHER'S MAIDEN NAME Freda McAboy	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 234-38-7576	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure		minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myelogenous leukemia		7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from January 16, 19 62 to February 27, 19 62 that (we) last saw the deceased alive on February 27, 19 62 , and that death occurred at 7:50 PM from the causes and on the date stated above.			
22a. SIGNATURE Robert H. Levin		22b. DATE SIGNED 2/28/62	
22c. PHYSICIAN'S NAME (Type) Robert H. Levin, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/2/62	23c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery	23d. LOCATION (City, town or county) (State) Charles Town, West Va.
24. FUNERAL DIRECTOR'S SIGNATURE F. Donald Zickler		25a. REC'D BY REGISTRAR DATE MAR 6 '62	
		25b. REGISTRAR'S SIGNATURE John S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



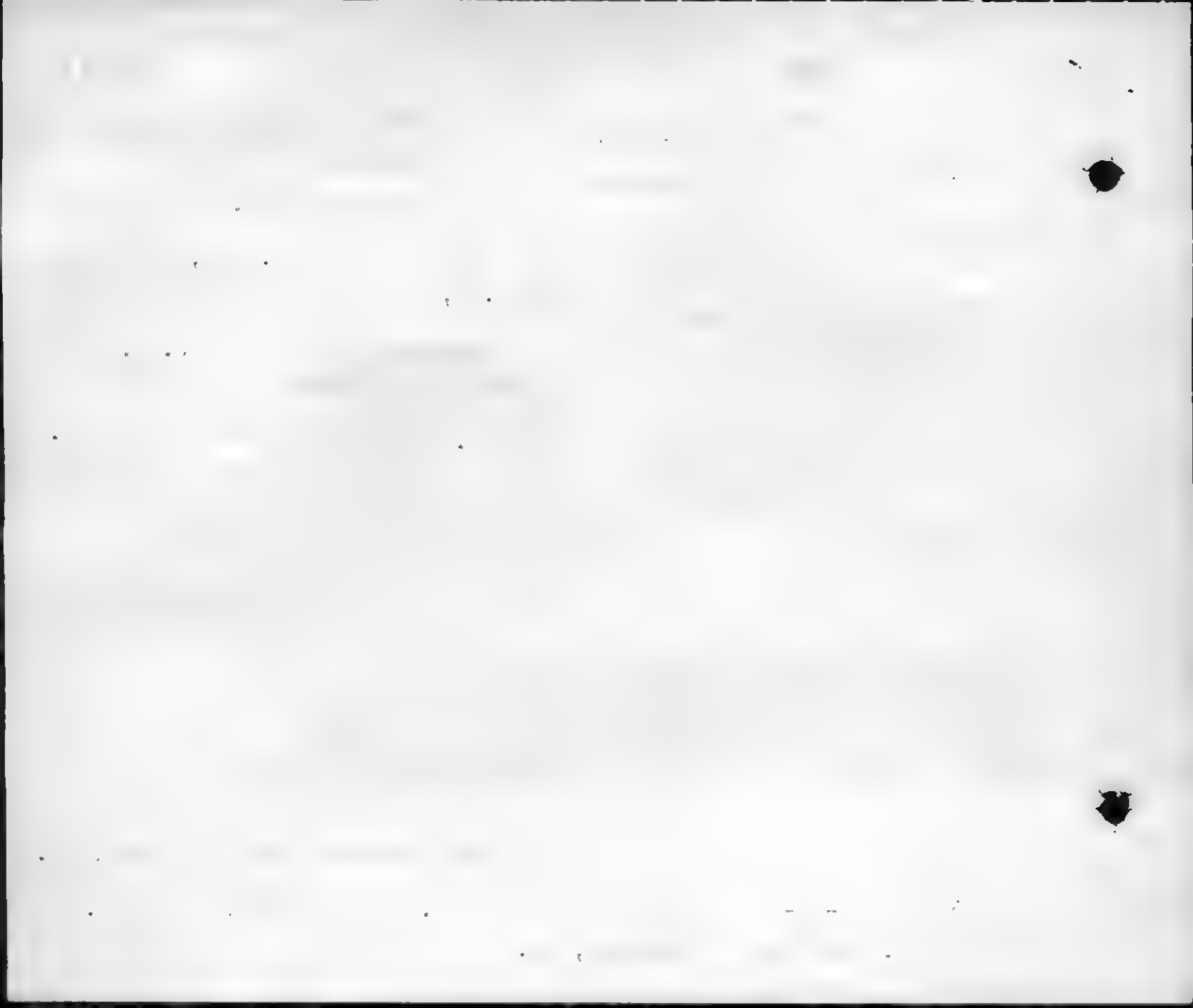
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02012

CERTIFICATE OF DEATH

01994

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm. ssion) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 10304 Montgomery Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NINA HOOD BRAZELTON		4. DATE OF DEATH Feb. 26, 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1882	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Hood		14. MOTHER'S MAIDEN NAME Valinte Yielding	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Son		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 174X IMMEDIATE CAUSE (a) Metastatic Carcinoma to Lung DUE TO Primary Carcinoma of Uterus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS 3 YRS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1957 to Feb. 1962 that (I) (we) last saw the deceased alive on Feb. 26, 1962 and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature] M.D.		22b. DATE SIGNED 2/27/62	
22c. PHYSICIAN'S NAME (Type) AEO I DONOVAN M.D.		22d. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-28-62	
23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		23d. LOCATION (City, town or county) (State) Arlington, Virginia.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE MAR 1 '62	
25b. REGISTRAR'S SIGNATURE [Signature]			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02013

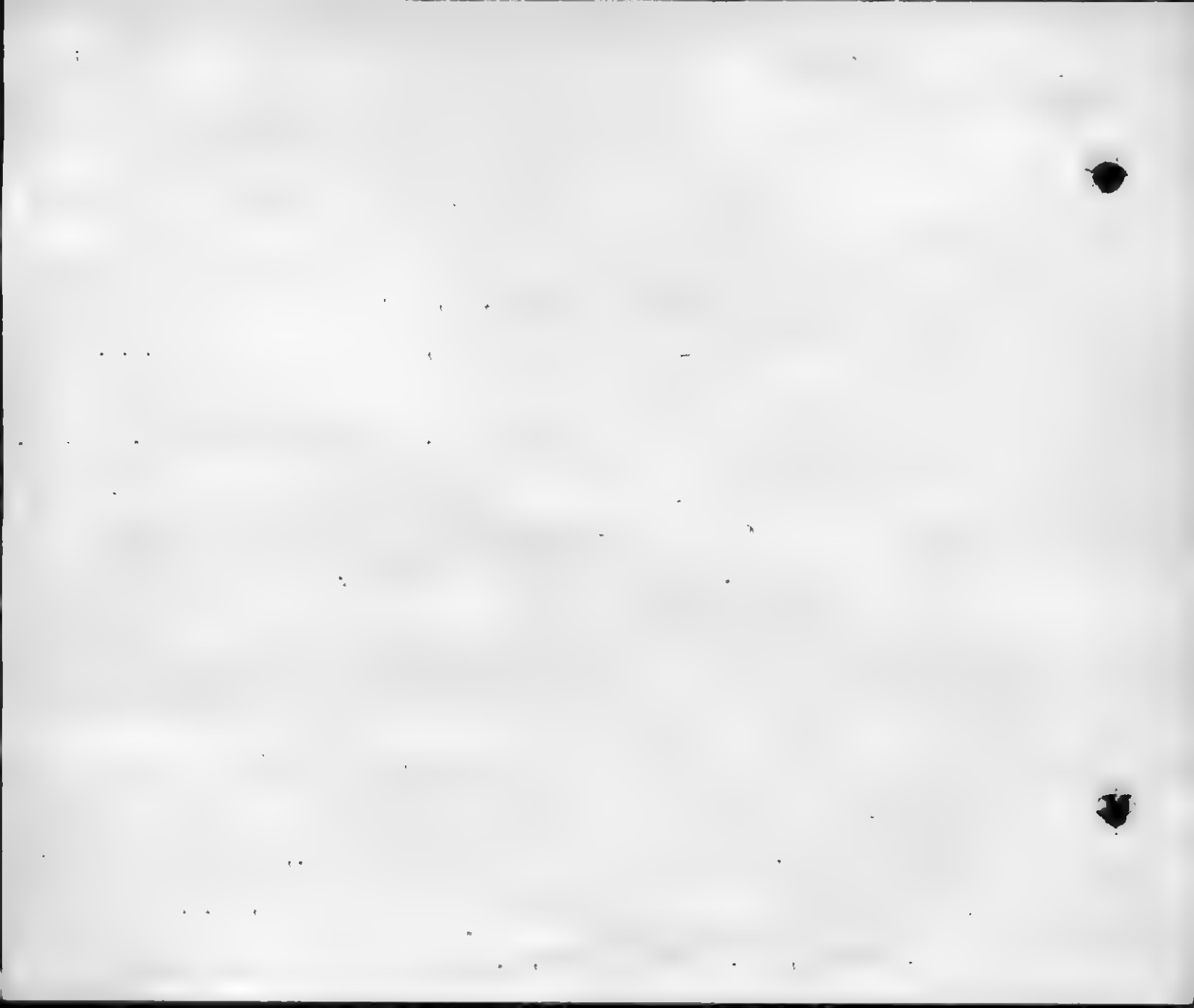
CERTIFICATE OF DEATH

01995

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>15 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marilea Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Chevy Chase</u> d. STREET ADDRESS <u>6420 Western Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Chase Briggs</u>		4. DATE OF DEATH Month Day Year <u>Feb. 13 1962</u>		5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 20, 1875</u>		9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own & home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Toledo, Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Herman Walbridge</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Walbridge</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Southwick W. Briggs</u> Address <u>6420 Western Ave. Chase, Md.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> (b) <u>bronchial pneumonia</u> (c) <u>chronic bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 day</u> <u>2 1/2 days</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>None</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)												20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1959</u> to <u>Feb 13, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 12, 1962</u> and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>John S. Rogers</u>								22b. DATE SIGNED <u>Feb 13 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>John S. Rogers</u>				22d. ADDRESS <u>1919 Seminary Rd., Silver Spring, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>2-16-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>								25a. REC'D BY REGISTRAR DATE <u>FEB 19 1962</u>		25b. REGISTRAR'S SIGNATURE <u>C. J. H. H.</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

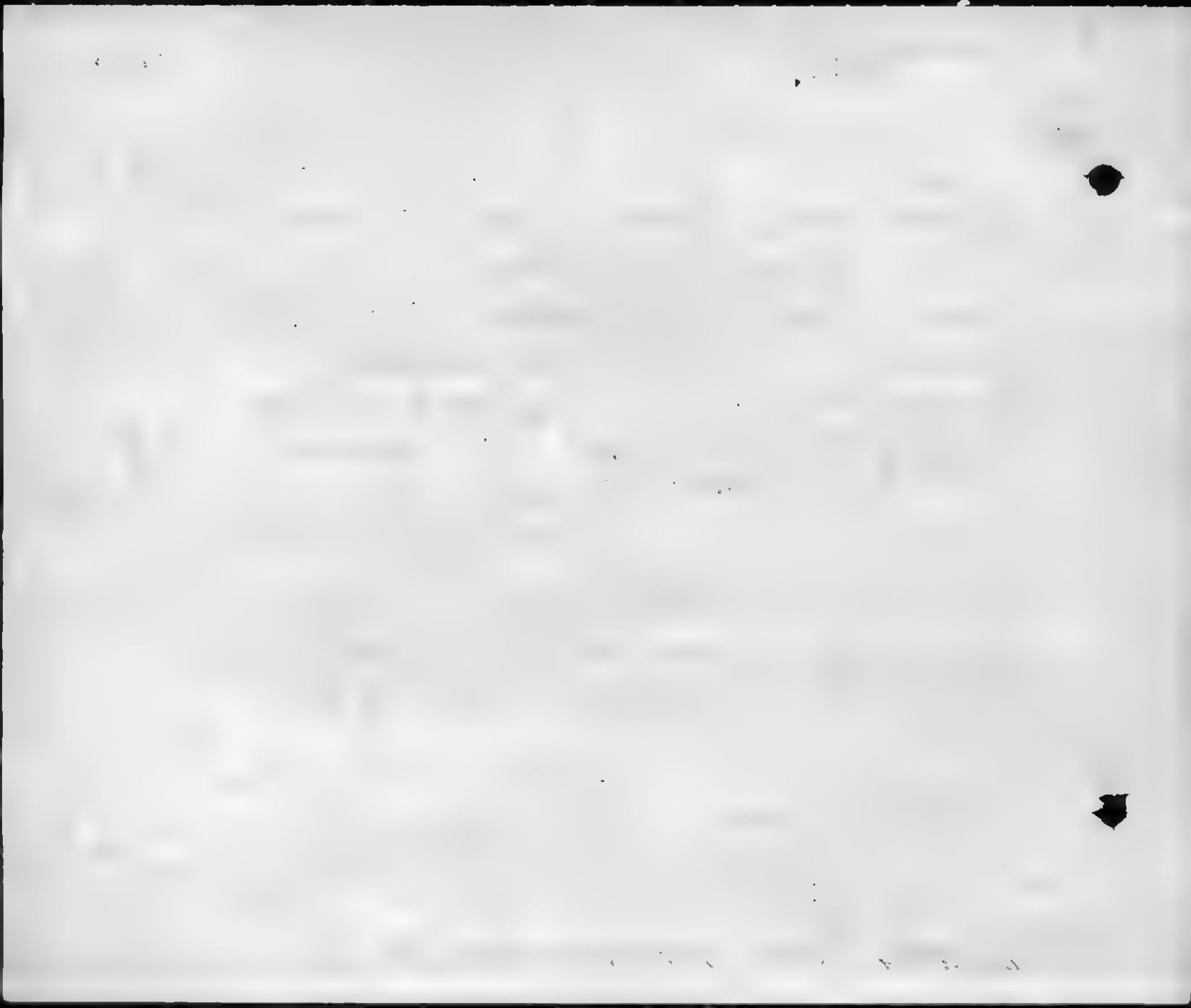
02014

CERTIFICATE OF DEATH

01996

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>10 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>+</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>4341-CHESAPEAKE ST. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PATRICK J. BRODERICK</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>6.</u> Year <u>1962</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 25TH 1882</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>48</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. GOVERNMENT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MICHAEL BRODERICK</u>		14. MOTHER'S MAIDEN NAME <u>SULIA DOODY</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-46-0969</u>		17. INFORMANT <u>SULIA BRODERICK</u> Address <u>2 D.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branchapneumonia</u> (b) <u>cardinal thrombosis with infarct of pons</u> (c) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>Washington</u>		20g. (County) <u>D.C.</u>		20h. (State) <u>D.C.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 27, 1962</u> to <u>present</u> , that (I) (we) last saw the deceased alive on <u>Feb 6, 1962</u> , and the death occurred at <u>12 noon</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>C P Ryland</u>		22b. DATE SIGNED <u>2-7-62</u>		22c. PHYSICIAN'S NAME (Type) <u>C P RYLAND</u>			
22d. ADDRESS <u>4400-44th St NW Washington 16 DC</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/9/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>			
23d. LOCATION (City, town or county) <u>WHEATON</u>		23e. (State) <u>MD.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hannon</u>		24a. ADDRESS <u>4748 Wisconsin Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 13 '62</u>			
25b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

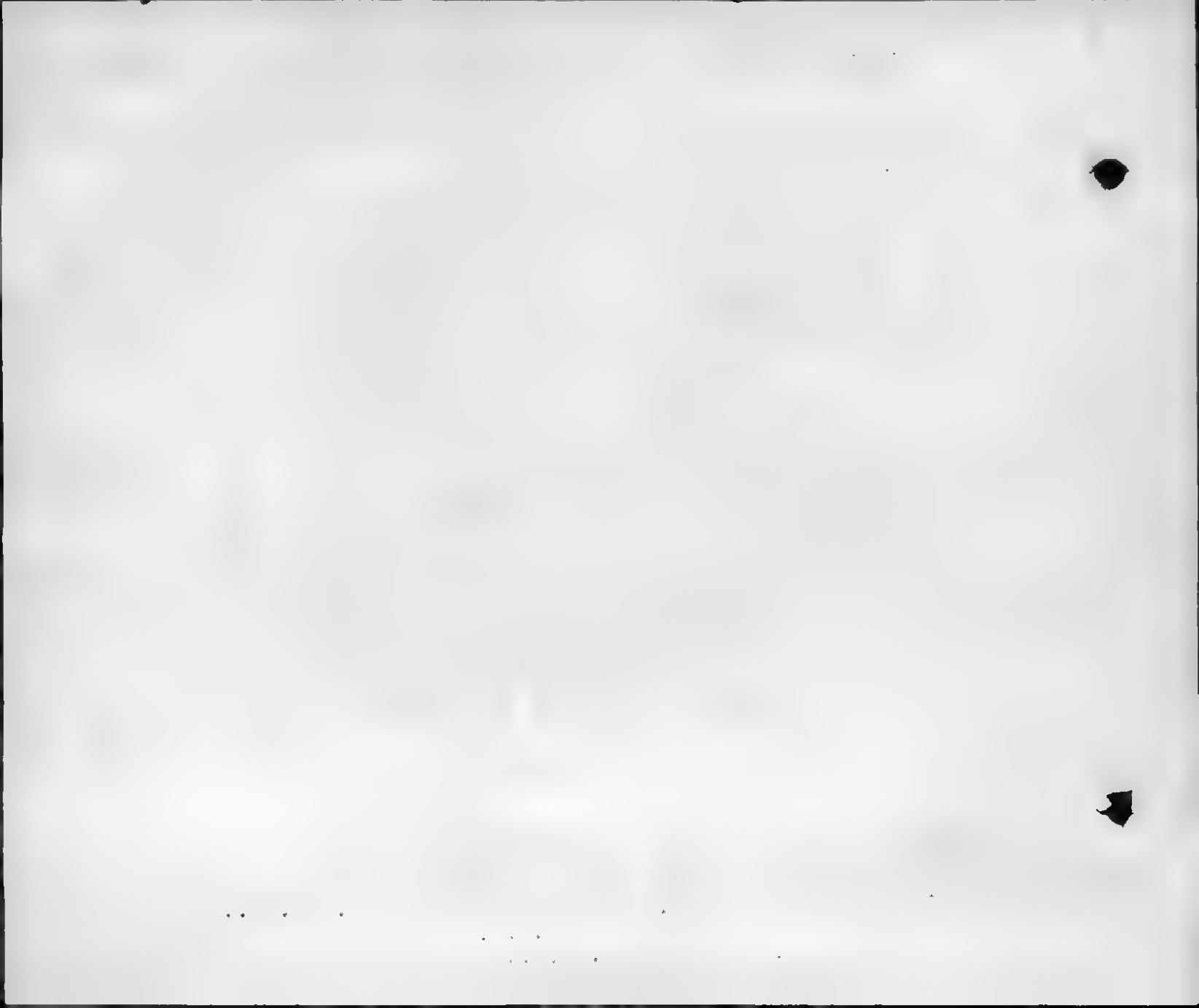


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02015 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01997

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u> c. LENGTH OF STAY in 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>2115 Rolander ST</u>	
3. NAME OF DECEASED (Type or print) <u>Hubert Lawrence Brown</u> First Middle Last 4. DATE OF DEATH <u>2 6 1962</u> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-08</u> 9. AGE (In years last birthday) <u>53</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>of Hardware S. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas P. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Anna Meyers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>578-05-8610</u>	
17. INFORMANT <u>Lynne Brown</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary occlusion</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/6/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co., 2901 14th St. N.W., Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>FEB 7 '62</u>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

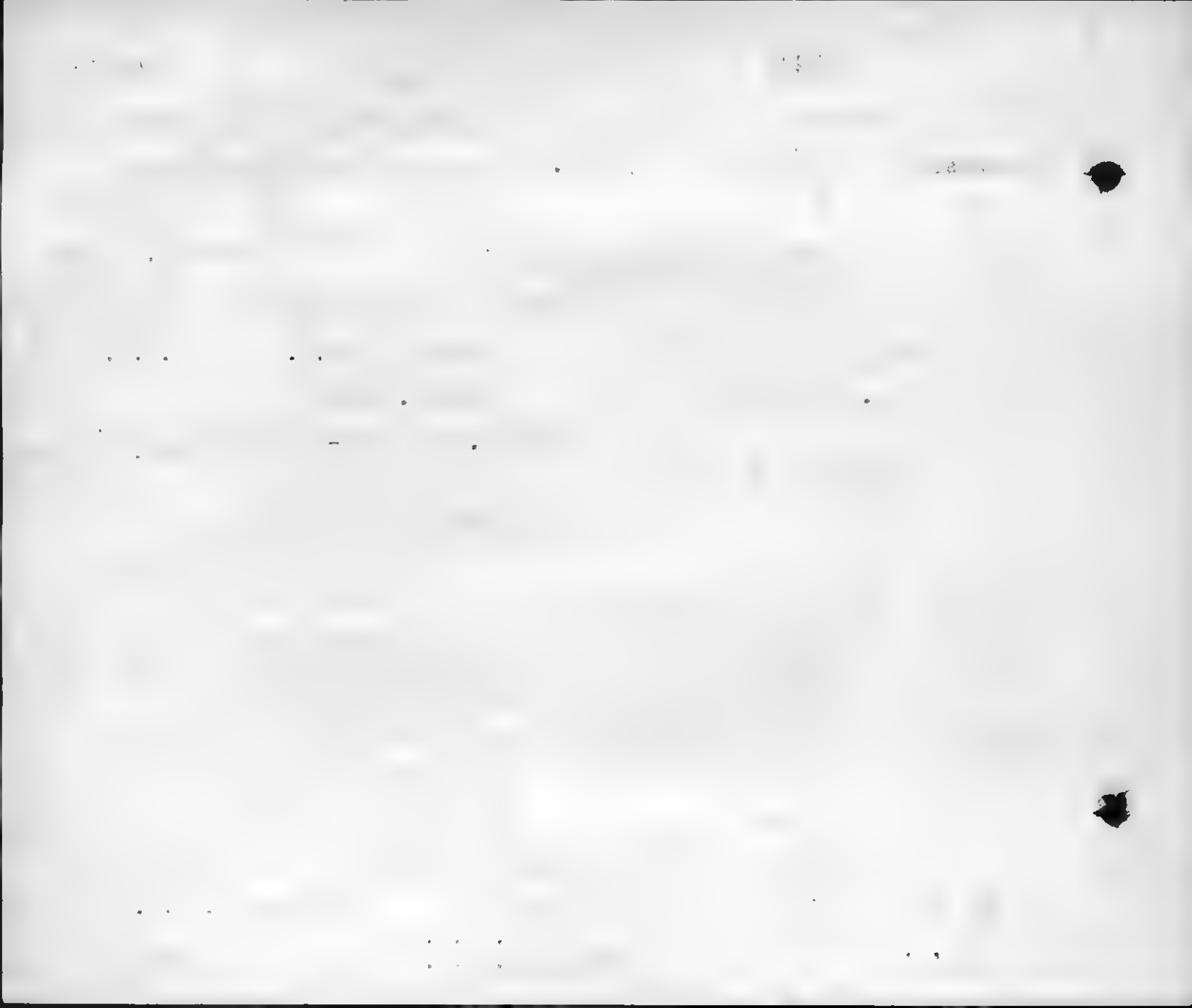
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02016

CERTIFICATE OF DEATH

01998

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Woodside Park) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Woodside Park) Silver Spring			
c. LENGTH OF STAY IN TB 7 years.				d. STREET ADDRESS 9008 Fairview Road			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9008 Fairview Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ethel Middle Rosetta Last Burdine				4. DATE OF DEATH Month February Day 5 Year 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/21/1906	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10		11. IF UNDER 24 HRS. Hours 1 Min 10			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.			
11. BIRTHPLACE (County & State, or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alfred H. Burdine				14. MOTHER'S MAIDEN NAME Mary E. Lytle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT James P. Casbarian				Address 9008 Fairview Road Silver Spring, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure							
DUE TO (b) Hypertensive Heart Disease							
DUE TO (c) Pneumonia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Chest Stenotomy from Polycystitis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1947 to Feb 5, 1962 that (I) (we) last saw the deceased alive on Feb 4, 1962 and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Harold Heigros M.D.				22b. DATE SIGNED 2/5/62			
22c. PHYSICIAN'S NAME (Type) Harold Heigros				22d. ADDRESS 1835 Eye St NW			
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 2/8/62		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company				25. REC'D BY REGISTRAR DATE FEB 7 '62			
25b. REGISTRAR'S SIGNATURE William S. Hines							

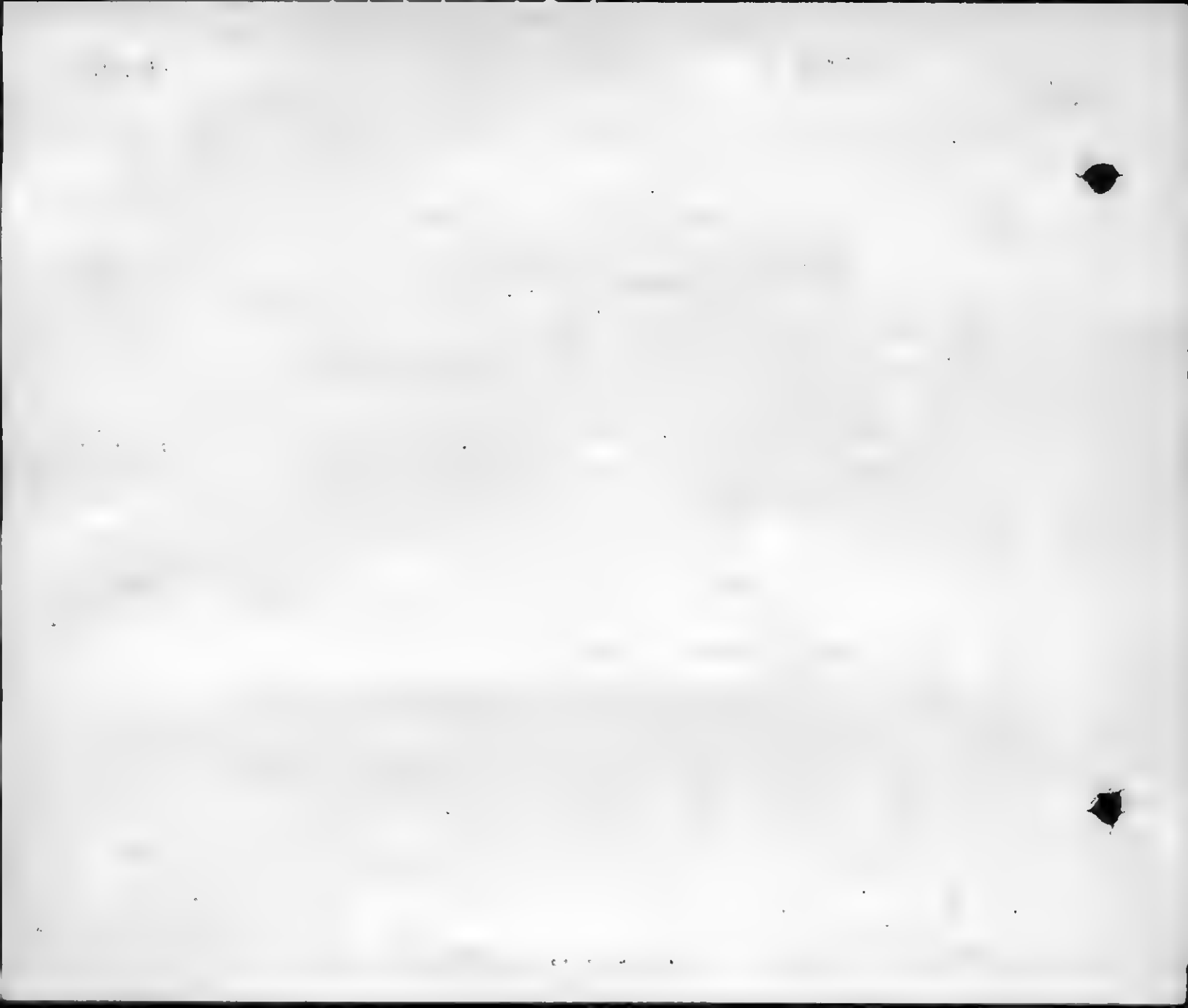


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02017 CERTIFICATE OF DEATH 01999

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN It <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanitorium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10410 Lorain Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAIE</u> First Middle Last 4. DATE OF DEATH <u>BURNS</u> Month <u>2</u> Day <u>10</u> Year <u>1962</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>28 Mar. 1865</u> 9. AGE (In years last birthday) <u>96</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Chas Co., W. Va.</u>		11. BIRTHPLACE (County & State or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dennis Unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u> 16. SOCIAL SECURITY NO. <u>Glenn C. Dorsey 10410 Lorain Ave., Sil. Sp., Md</u> 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Myocarditis & Angina</u> causing the underlying cause last. (c) <u>Acute Bronchopneumonia 1/29/62 to 2/7/62</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>17 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u>9/11/1938</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bus, etc.) <u>1 AM</u> 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/27/62</u> to <u>2/10/62</u> , that (I) (we) last saw the deceased alive on <u>2/7/62</u> , and that death occurred at <u>3:35 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard T. Morse</u> M.D. 22b. PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>		22c. ADDRESS <u>7030 Carroll Ave. Takoma Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-12-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Frederick, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 14 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Chas E. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02018 02000

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 1 week c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Jubertown Hospital</u>		2. USUAL RESIDENCE (Where deceased lived; if inst. in hon., Residence before admission) a. STATE <u>Dist. of Co.</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 4:15 d. STREET ADDRESS <u>3636-16th St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie</u> FURMAN First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10/18/78</u> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____		4. DATE OF DEATH <u>Feb. 15</u> 19 <u>62</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Nathan I. Furman</u> 14. MOTHER'S MAIDEN NAME <u>Walls mitch</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>H. Scott Byerly</u> Address <u>6409-31st N.W. Washington, D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> (b) <u>Anterior wall MI</u> (c) <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town, (County) (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from _____, 19<u>62</u>, to _____, 19<u>62</u>, that (I) (we) last saw the deceased alive on _____, 19<u>62</u>, and that death occurred at _____, 19<u>62</u>, from the causes and on the date stated above.			
22a. SIGNATURE <u>Donald Ekman</u> 22c. PHYSICIAN'S NAME (Type) <u>Donald Ekman</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>5707 Wisconsin Ave., Chevy Chase, Maryland</u> 22b. DATE SIGNED <u>2-15-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-19-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Pomfret Manor Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sunbury Northumberland Co. Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Humphrey</u> ADDRESS <u>8434-22nd Ave SE, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 19 1962</u> 25b. REGISTRAR'S SIGNATURE _____	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02019

CERTIFICATE OF DEATH

02001

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in b. <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>12039 Valleywood Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Carl Jerome</u> First <u>Bylsma</u> Middle 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 25, 1962</u> 9. AGE (In years last birthday) <u>3 days</u> 10. IF UNDER 1 YEAR Months <u>2</u> Days <u>05</u> Hours <u>00</u> Min. <u>00</u> 11. BIRTHPLACE (County & State or foreign country) <u>Maryland U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Roger B. Bylsma</u> 14. MOTHER'S M.A.D.N. NAME <u>Theresa L. Carlson</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>Mothers' Chart</u> 17. INFORMANT <u>Mothers' Chart</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>PREMATURITY</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> , 19 <u>62</u> , to <u>2/28</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2-28</u> , 19 <u>62</u> , and that death occurred at <u>8 P.</u> M., from the causes and on the date stated above.								22a. SIGNATURE <u>John W. Pearlman</u> M.D. 22c. PHYSICIAN'S NAME (Type)	
22b. DATE SIGNED <u>2-28-62</u>				22d. ADDRESS <u>4700 Bradley Blvd., Chevy Chase, Md.</u>				25a. REC'D BY REGISTRAR <u>6 '62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3-3-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	
23d. LOCATION (City, town or county) (State) <u>Montgomery County, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>W. Don DeVol</u>				25c. ADDRESS <u>2224 Wise Ave. N.W.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

-2-4-552



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02020

CERTIFICATE OF DEATH

02002

Item 9 Film 3301 c/26/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Chevy Chase Village</u> c. LENGTH OF STAY IN 1b <u>13 Wks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>#8 W LenoX St</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Chevy Chase Village</u> d. STREET ADDRESS <u>#8 W LenoX St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>AGNES</u> Last <u>BYRNE</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1962</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Dec 25 1875</u>		9. AGE (In years last birthday) <u>86 1/2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Jersey City N.J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Dorrick K. BYRNE</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Hickey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>GRACE T. CAUFIELD</u> Address <u>C.C. Md. + #8 W. LENOX ST</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aortic Aneurysm</u> DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Arterio Sclerosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteo-Arthritis</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town, (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 15</u> 19 <u>62</u> to <u>Feb 20</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Feb 20</u> 19 <u>62</u> and that death occurred at <u>12 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Philip A. Caufield</u>		22b. DATE SIGNED <u>Feb 20 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>Philip A. Caufield</u>	
22d. ADDRESS <u>2701 Conn. Ave. N.W. Wash D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE THEREOF <u>2-22-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary Cemetery</u>	
23d. LOCATION (City, town or county) <u>Rockville</u>		(State) <u>MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don Welol</u>		25a. REC'D BY REGISTRAR <u>FEB 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
ADDRESS <u>2224 W. 4th Ave. N.W.</u>		DATE			



CERTIFICATE OF DEATH

Reg. Dist. No. 02003

02021

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CHEVY CHASE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7302 POMANDER LANE		d. STREET ADDRESS 7302 POMANDER LANE	
3. NAME OF DECEASED (Type or print) First Middle Last MICHAEL P. CALLAGHAN		4. DATE OF DEATH Month Day Year 2-28-1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-4-67
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY CHEVY CHASE, D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOHN O'CALLAGHAN		14. MOTHER'S MAIDEN NAME HONORA DUNSTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS. PATRICK J. Mc CARTHY Address (SAME AS #1)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO CEREBRAL ARTERIOSCLEROSIS DUE TO GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 3 months 7 years 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GOUTY ARTHRITIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 1954 to FEB 28, 1962 that I last saw the deceased alive on FEB 27, 1962 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Blaine Fitzgerald		ADDRESS (Street, city or town, state) 8218 WISCONSIN AVE. BETHESDA, MD.	
PHYSICIAN'S NAME (Type) BETHESDA, MD.		DATE SIGNED 2-28-62	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3-3-62	St. John's Cemetery	Forest Glen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		24a. REC'D BY REGISTRAR 5 '62	
ADDRESS 3821-14th St. N.W. Wash. D.C.		24b. REGISTRAR'S SIGNATURE William S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

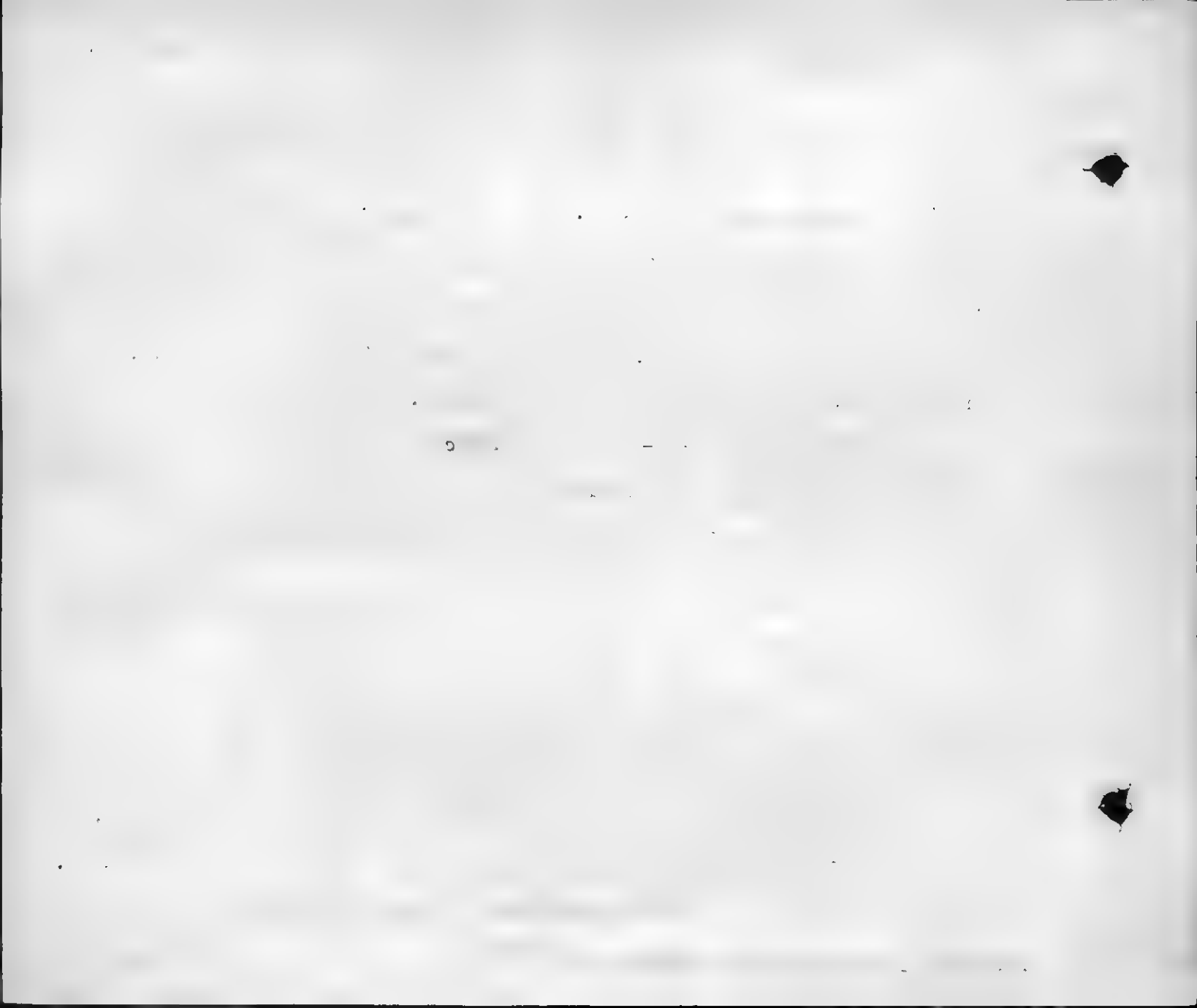


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove each of the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A111 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02022
CERTIFICATE OF DEATH
02004

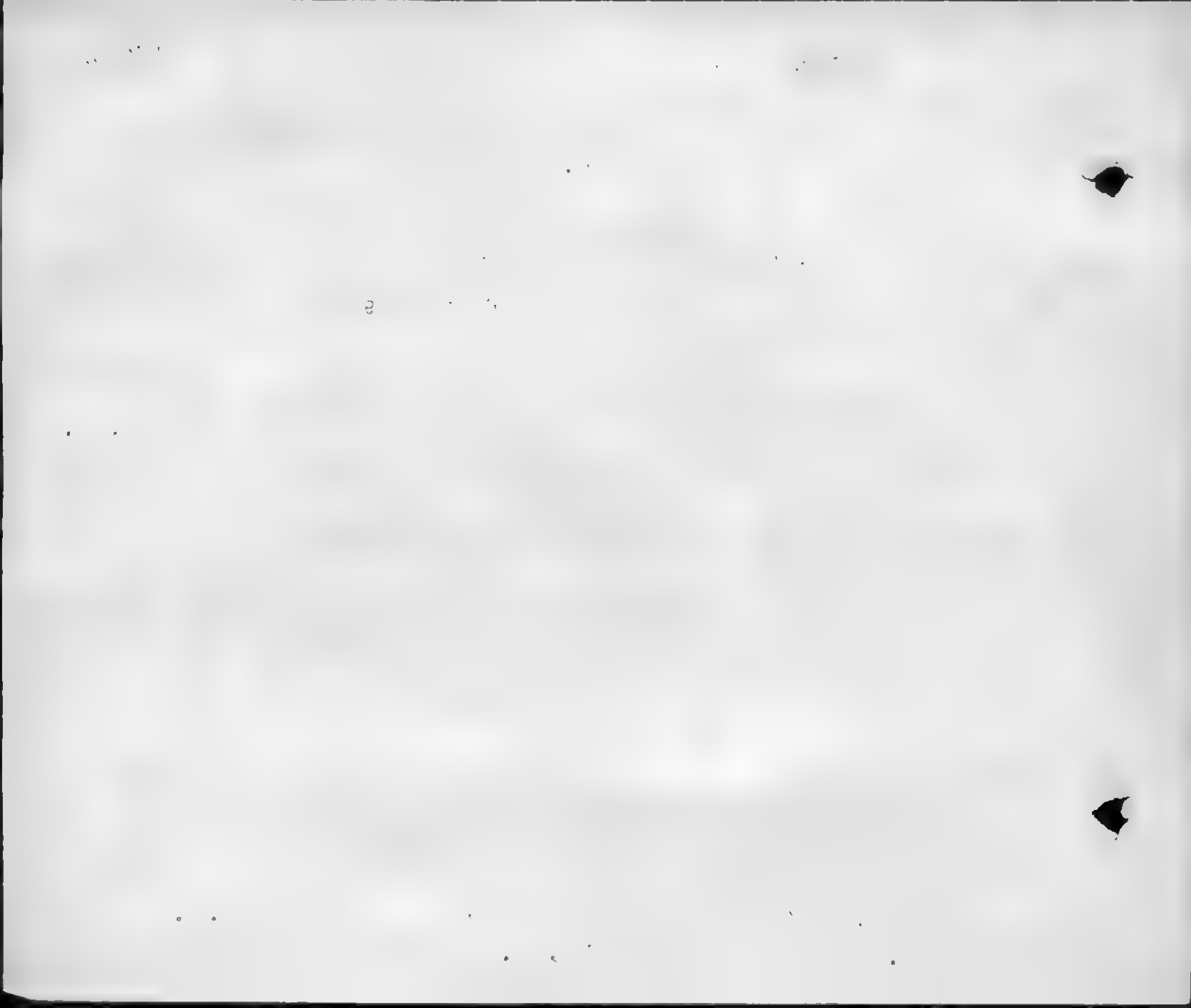
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>48 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7711 Greenwood Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence Reese Campbell</u>		4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>October 1, 1941</u>		9. AGE (In years last birthday) <u>20</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roofing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roofing</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Everett Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Lottie B. Cash</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>224-48-254</u>	
17. INFORMANT <u>The Clinical Center, Bethesda 14, Maryland</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency</u> DUE TO (b) <u>Undifferentiated tumor primary in Prostate gland</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>with Pulmonary Metastases</u> X		19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 year</u>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from <u>January 2, 1962</u> to <u>February 19, 1962</u> , that (B) (we) last saw the deceased alive on <u>February 19, 1962</u> , and that death occurred at <u>12:15 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Michael Field</u> M.D.		22b. DATE SIGNED <u>February 20, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Michael Field</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/24/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Stonewall Mems. Soc. Manassas Va.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington D.C.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 23 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02023		02005									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b. 26 1/2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 185 Seven Lock Road					
3. NAME OF DECEASED (Type or print) Virginia						4. DATE OF DEATH February 18, 1962					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1909		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (County & state, or foreign country) U.S.A.			
13. FATHER'S NAME George Howard						14. MOTHER'S MAIDEN NAME Elizabeth ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO. 17. INFORMANT Ernest Claggett(son) 185 Seven Lock Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) auricular fibrillation DUE TO (b) arteriosclerotic heart disease DUE TO (c) 11 yrs.						INTERVAL BETWEEN ONSET AND DEATH 2 mos.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2 - 12 1962 to 2 - 18 1962 ; that (I) (we) last saw the deceased alive on 2 - 12 1962 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Garthby Hill						22b. DATE SIGNED 2 - 18 - 62					
22c. PHYSICIAN'S NAME (Type) Robert L. Snowden						22d. ADDRESS Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/21/62		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION (City, town or county) (State) Washington, D. C.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden						25a. REC'D BY REGISTRAR FEB 21 '62		25b. REGISTRAR'S SIGNATURE W. H. H. H.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

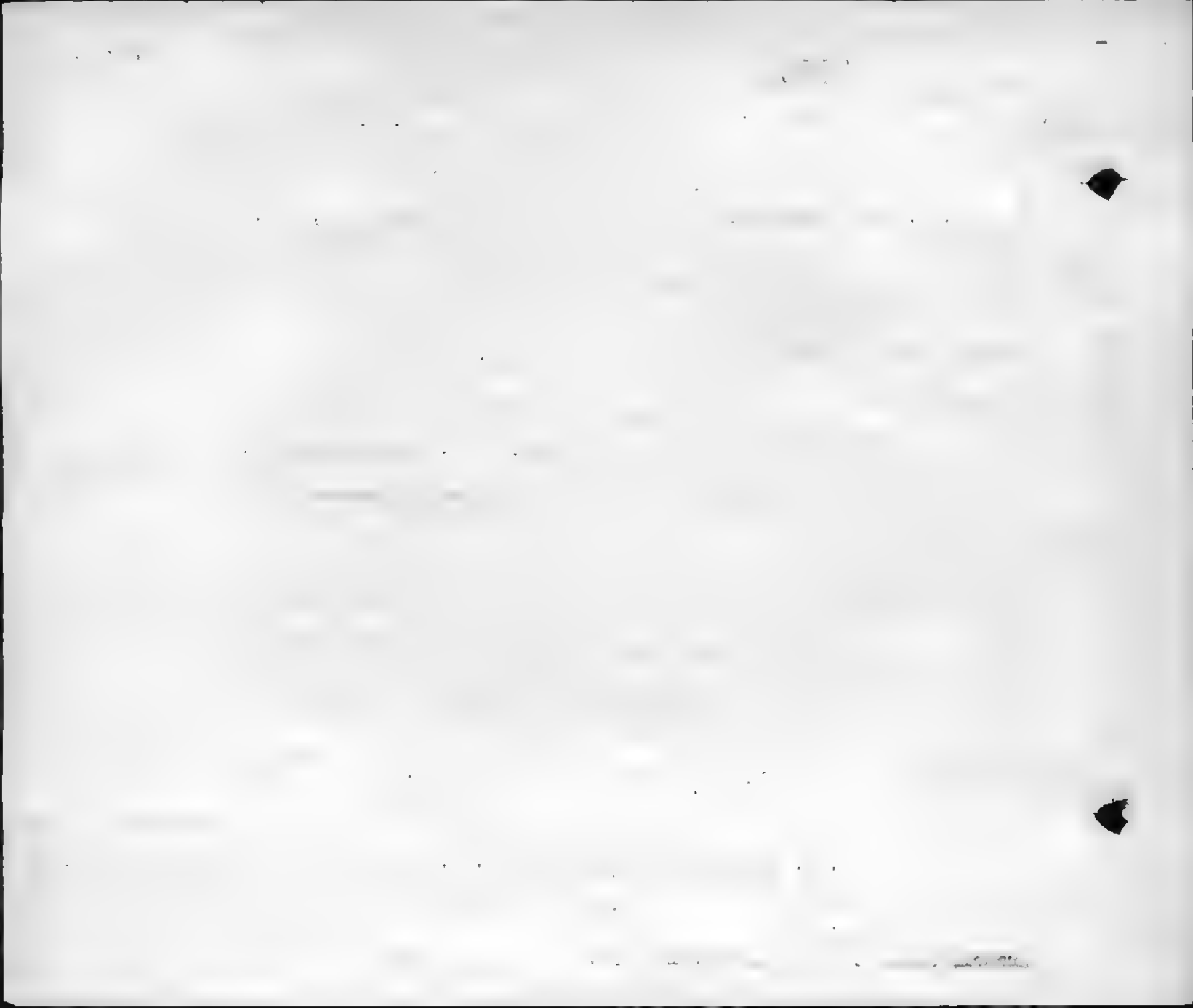
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02024

02006

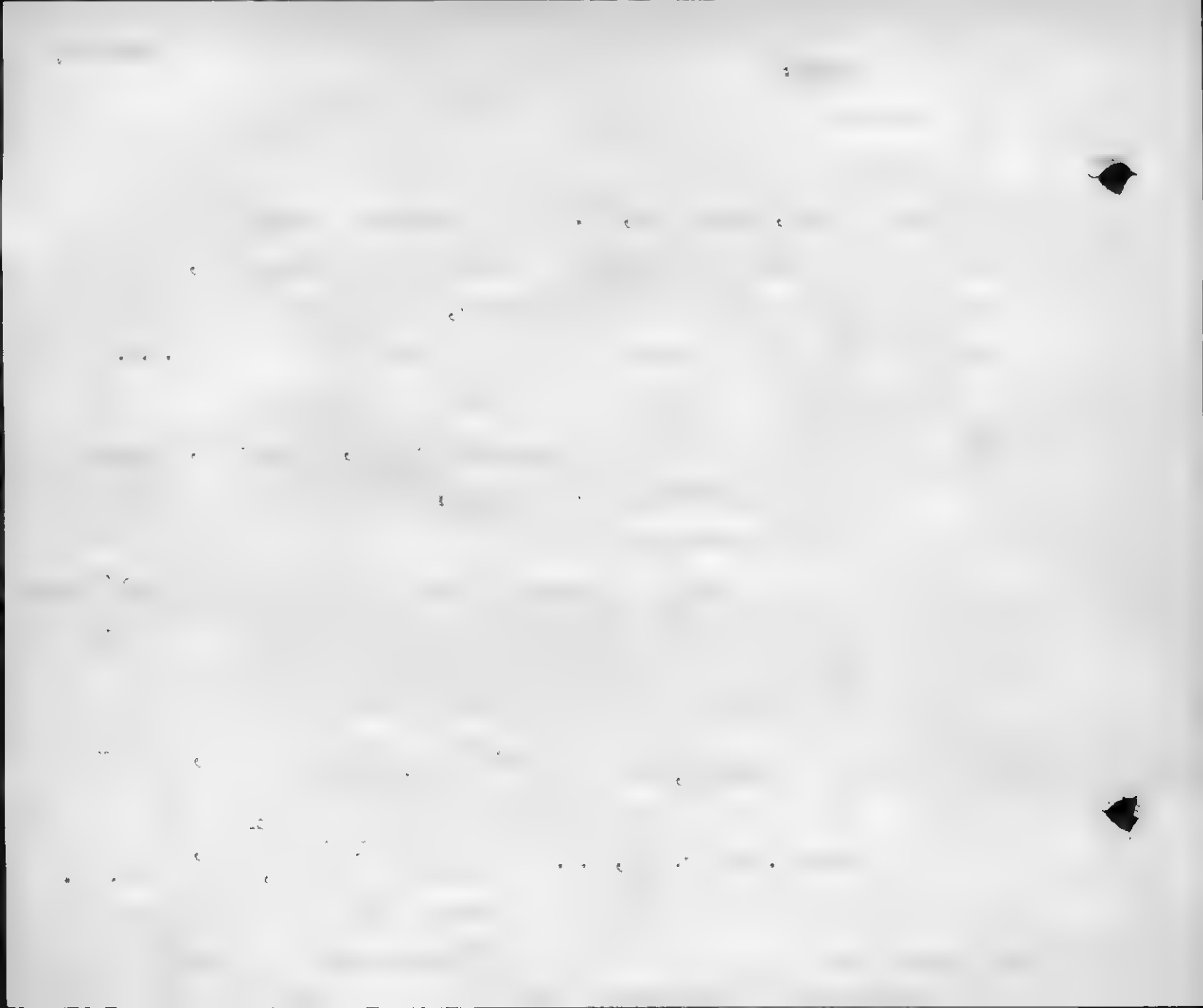
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>D. C.</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1316 T Street SE, Apt. #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur</u> <u>(n)</u> <u>Clemons</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>November 19, 1899</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____		4. DATE OF DEATH <u>February 18, 1962</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fred Clemons</u> 14. MOTHER'S MAIDEN NAME <u>Hattie Denure</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WW I</u> <u>WW II</u> 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Wife: Mrs. Pauline Clemons, Same as #2</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Right Colon with Metastases</u> 153.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 11, 1962</u> , to <u>Feb. 18, 1962</u> , that <u>(u)</u> (we) last saw the deceased alive on <u>Feb. 18, 1962</u> , and that death occurred <u>2:13 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M. C. Jorgensen</u> 22c. PHYSICIAN'S NAME (Type) <u>M. C. JORGENSEN LT MC USN</u>		22b. DATE SIGNED <u>February 19, 1962</u> M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-21-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 23d. LOCATION (City, town or county) <u>Arlington, Virginia</u> (State) _____		24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch & Sons</u> 24b. ADDRESS <u>Hyattsville, Md.</u> 25a. REC'D BY REGISTRAR <u>DATE FEB 21 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



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2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02025
02007
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Alaska b. COUNTY Noorvik c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (No street address) d. STREET ADDRESS (No street address) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) John George Coffin		4. DATE OF DEATH Month February , Day 7 , Year 1962		5. SEX Male		6. COLOR OR RACE Yellow		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month July , Day 12 , Year 1959		9. AGE (In years last birthday) 2 yrs. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State or foreign country) Alaska				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Coffin				14. MOTHER'S MAIDEN NAME Mary Lou (Unknown)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Records				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 2890 DUE TO Conditions, if any, which gave rise to immediate cause (b) Pneumonia (a), stating the underlying cause last. (c) Hand Shuller Christian Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 1/2 years				INTERVAL BETWEEN ONSET AND DEATH 2 hours 1 day 2 1/2 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 23 to February 7, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 7, 1962 , and that death occurred at 8:15 PM from the causes and on the date stated above.							
22a. SIGNATURE Geo. H. Porter III				22b. DATE SIGNED 2/10/62				22c. PHYSICIAN'S NAME (Type) George H. Porter, III, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-13-62				23c. NAME OF CEMETERY OR CREMATORY Washington National				23d. LOCATION (City, town or county) Suitland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				24a. ADDRESS 6-8655-1a Ave. S. S. Md.				25a. REC'D BY REGISTRAR 13 '62				25b. REGISTRAR'S SIGNATURE 1-1-8 Tuma			



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

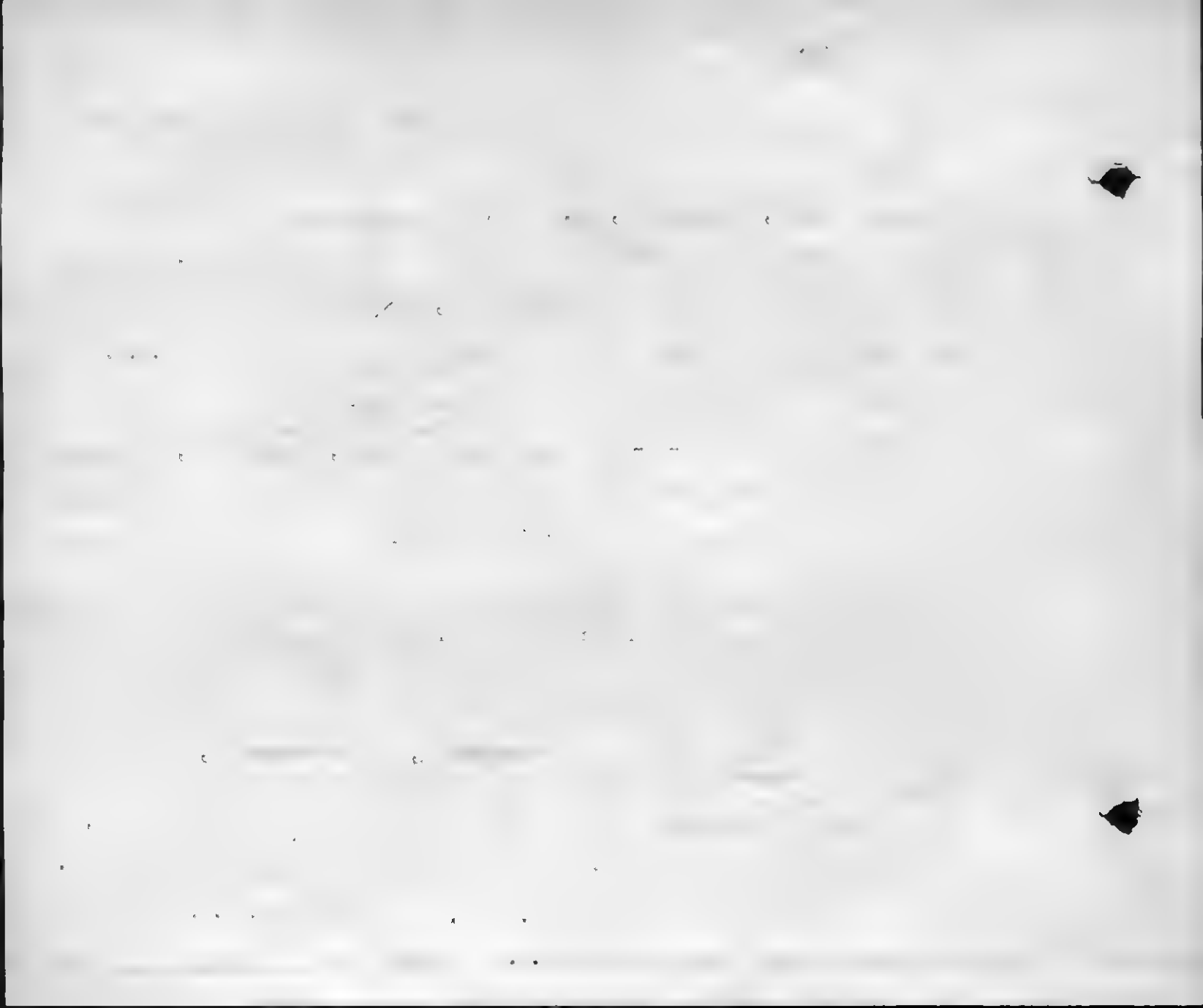
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02026

CERTIFICATE OF DEATH

02008

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6416 Marjory Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rose 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> D. VORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH August 21, 1903 9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR: Months 19 Days 62 IF UNDER 24 HRS. Hours 19 Min.		4. DATE OF DEATH February 27, 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper 10b. KIND OF BUSINESS OR INDUSTRY Office 11. BIRTHPLACE (County & State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Wolf 14. MOTHER'S MAIDEN NAME Jennie Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO 16. SOCIAL SECURITY NO. 102-01-4109 17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Embolus 20. DUE TO (b) Recent acute myocardial infarction 21. DUE TO (c) 4 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary fibrosis; adhesive pericarditis; Carcinoma of the Breast		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year February 12, 1962 Hour a.m. 7:15 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) The Clinical Center, Bethesda 14, Md. 20f. (City or town) Bethesda (County) Montgomery (State) Md.		21. I certify that (a) (this hospital) attended the deceased from February 12, 1962 to February 27, 1962 that (b) (we) last saw the deceased alive on February 27, 1962 and that death occurred at 7:15 p.m. from the causes and on the date stated above.	
22a. SIGNATURE Michael Field 22c. PHYSICIAN'S NAME (Type) Michael Field M.D. 22b. DATE SIGNED February 28, 1962		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF Feb 28, 1962 23c. NAME OF CEMETERY OR CREMATORY Schwartz Bros., Inc. 23d. LOCATION (City, town or county) New York, N.Y. (State) N.Y.		24. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home ADDRESS 4217 9th Street N.W. 25a. REC'D BY REGISTRAR DATE MAR 2 '62 25b. REGISTRAR'S SIGNATURE James S. House	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

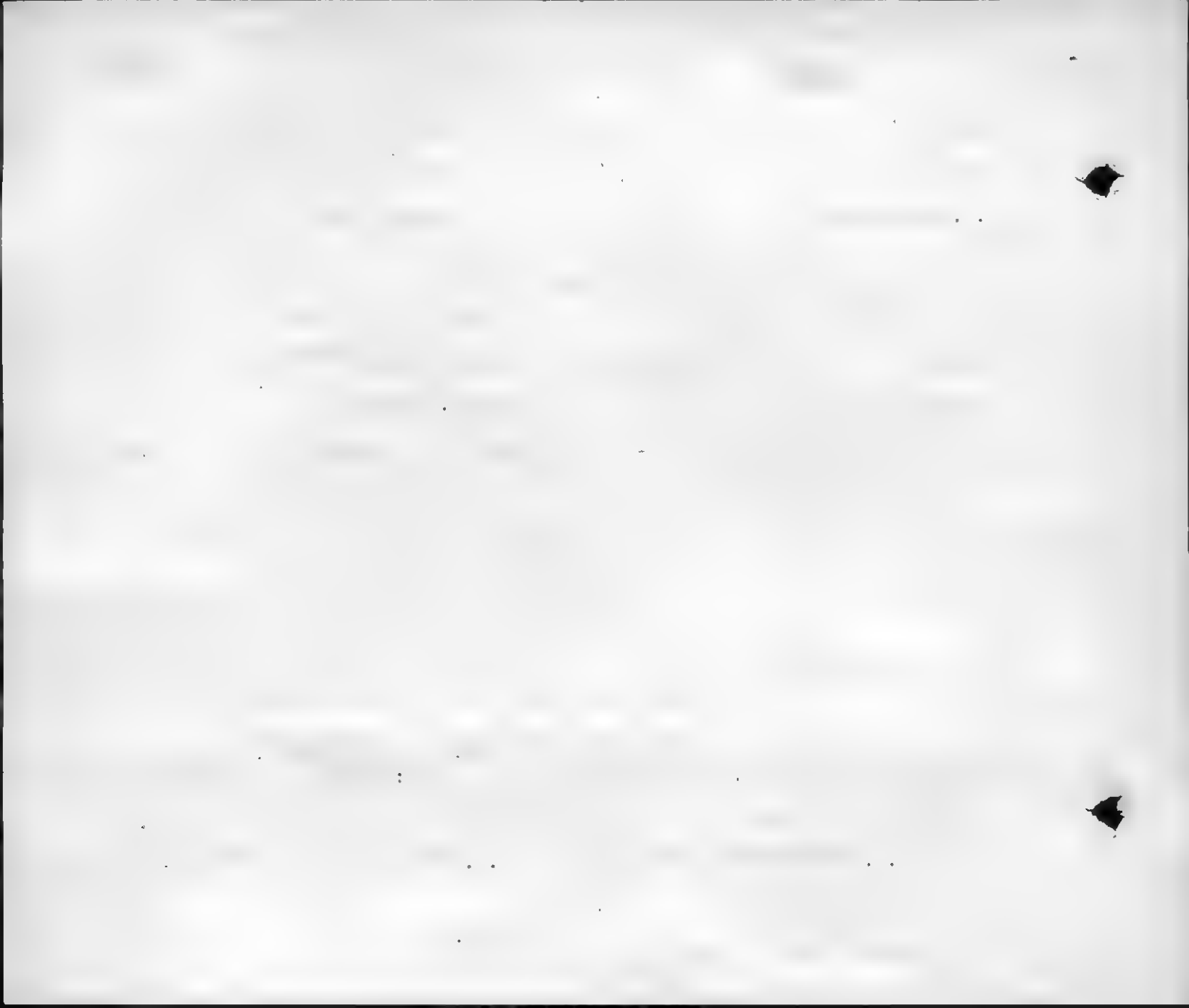
Item 25b, file G206 2/9/62 iwk

02027

02009

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural) c. LENGTH OF STAY IN 1b 20 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. NAVAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE FLORIDA b. COUNTY JACKSONVILLE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) JACKSONVILLE d. STREET ADDRESS RT 7 BOX 518 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ina Raye COKER		4. DATE OF DEATH Month FEB Day 2 Year 1962	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-52
9. AGE (in years last birthday) 9 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Jacksonville, Florida	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey Neil COKER		14. MOTHER'S MAIDEN NAME Mary R. TRIESTE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number or dates of service) No		16. SOCIAL SECURITY NO. (F) Harvey Neil COKER	
17. INFORMANT Same as #2 above		Address	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9 yrs DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 14 Jan., 1962 to 2 Feb., 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2 Feb., 1962 , and that death occurred at 2:25 PM on the causes and on the date stated above.			
22a. SIGNATURE C.W. Bramlett M.D.		22b. DATE SIGNED 2 FEB. 1962	
22c. PHYSICIAN'S NAME (Type) C.W. BRAMLETT LCDR MC USN		22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Feb. 7, 1962	23c. NAME OF CEMETERY OR CREMATORY HAMPTON CEMETERY	23d. LOCATION (City, town or county) (State) HAMPTON, FLORIDA
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		25a. REC'D BY REGISTRAR FEB 6 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas		25c. REGISTRAR'S NAME Charles S. Thomas	

MEDICAL CERTIFICATE ON



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

02028

02010

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>39 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>17,001 LEMAY RD</u>			
3. NAME OF DECEASED (Type or print) <u>LEONARD PETER COLANGELO</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-23</u>	
9. AGE (in years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRONIC ENGINEER GENERAL ELECTRIC</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		13. FATHER'S NAME <u>Dominic Colangelo</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>1942-1945</u>			
16. SOCIAL SECURITY NO. <u>106-14-8883</u>				17. INFORMANT <u>WIFE</u> Address <u>SAME ADDRESS</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia with pulmonary abscess, lower lobes</u> (b) <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Polycystic</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February 12, 1962</u> to <u>February 21, 1962</u> , that (I) (we) last saw the deceased alive on <u>February 21, 1962</u> , and that death occurred at <u>6:12 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Blaine Fitzgerald</u>				22b. DATE SIGNED <u>February 21, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. Blaine Fitzgerald</u>				22d. ADDRESS <u>8218 Wisconsin Avenue Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/26/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary</u>		23d. LOCATION (City, town or county) (State) <u>Chicktown New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> Home <u>1331 East Montg Ave Rockville Maryland</u>				25. REC'D BY REGISTRAR DATE <u>FEB 26 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>G. S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02029

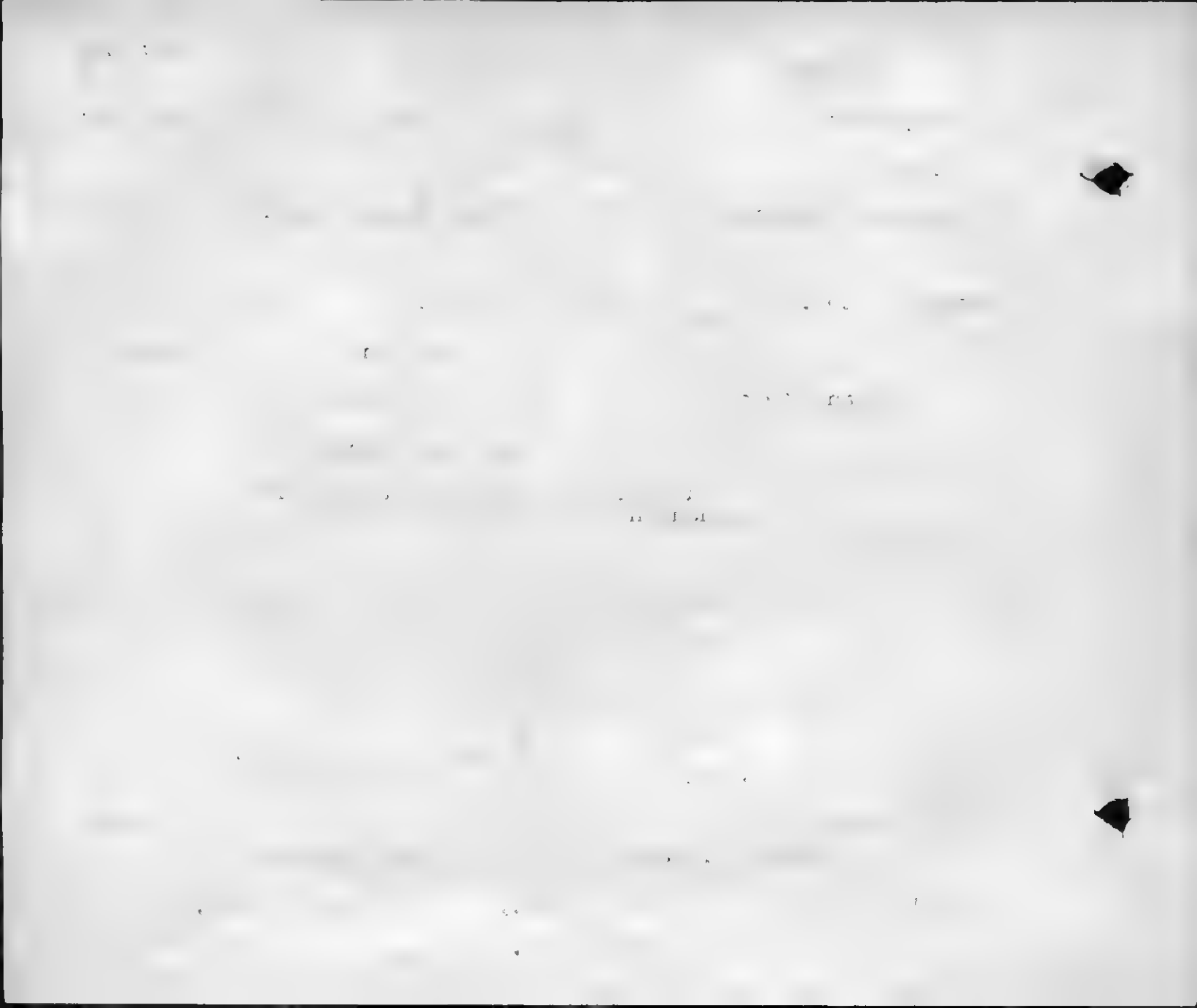
02011

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Norwood d. STREET ADDRESS Cl21 Silver Spring	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last COOK		4. DATE OF DEATH Month 2 Day 1 Year 1962	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14/62
9. AGE (In years last birthday) 18		10. IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min. 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Roland Cook	
14. MOTHER'S MAIDEN NAME Alice White		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Tracheobronchitis and broncho Pneumonia 500X DUE TO (b) 3 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)	
20h. (State)		21. I certify that (I) (this hospital) attended the deceased from 1/14/62 to 2/1/62 , that (I) (we) last saw the deceased alive on 1/31/62 , and that death occurred at 3:05am , from the causes and on the date stated above.	
22a. SIGNATURE Richard A. Yates		22b. DATE SIGNED 2/1/62	
22c. PHYSICIAN'S NAME (Type) Richard A. Yates, M.D.		22d. ADDRESS Olney, Maryland	
23a. BURIAL, CREMATION	23b. DATE THEREOF 2/2/62	23c. NAME OF CEMETERY OR CREMATORY Ash Memorial.	23d. LOCATION (City, town or county) Sandy Spring, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sumner		25a. REC'D BY REGISTRAR 13 '62	
25b. REGISTRAR'S SIGNATURE Robert L. Sumner		25c. ADDRESS Rockville, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

297152

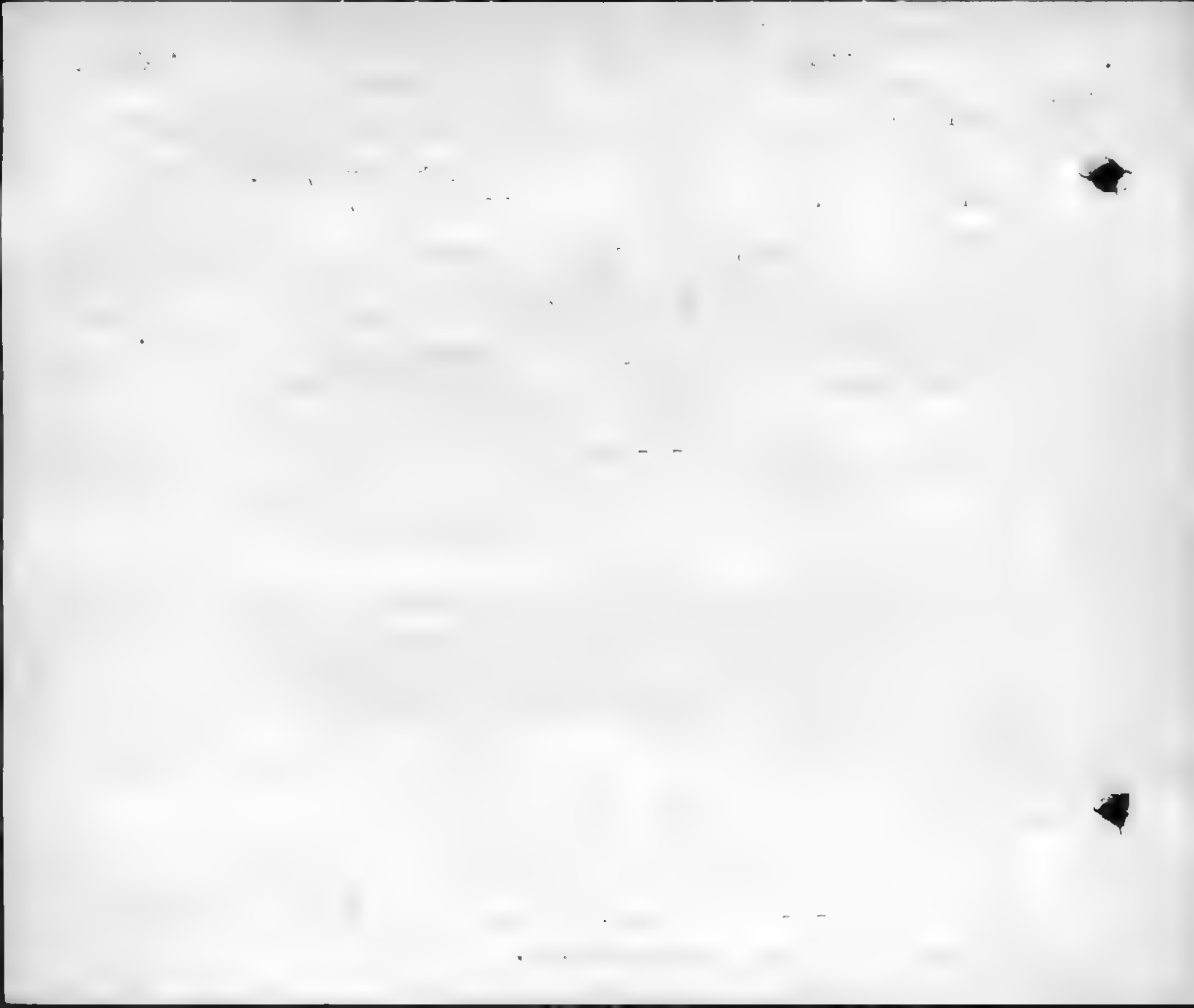


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02030						02012					
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Md. d. STREET ADDRESS Warfield Rd., Rt 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William Riley Cook						4. DATE OF DEATH Month 2 Day 15 Year 1962					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/15/1877		9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber				10b. KIND OF BUSINESS OR INDUSTRY Sawmill				11. BIRTHPLACE (County & State, or foreign country) North Carolina			
13. FATHER'S NAME James Cook				14. MOTHER'S MAIDEN NAME Mary Jane Hodge				12. CITIZEN OF WHAT COUNTRY? U.S.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 218-10-8406				17. INFORMANT Hospital records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitabacter Concom of stomach Conditions, if any, which gave rise to immediate cause (b) 151X (c) DUE TO Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Generalized arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JAN 20 , 1962 to Feb 15 , 1962, that (I) (we) last saw the deceased alive on 2/14 , 1962, and that death occurred at 1:15 PM , from the causes and on the date stated above											
22a. SIGNATURE G.F. MEADORS, MD						22b. DATE SIGNED 2/15/62		22c. ADDRESS DAMASCUS, MD			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-17-62				23c. NAME OF CEMETERY OR CREMATORY Laytonsville			
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				24a. ADDRESS Laytonsville, Md.				24b. LOCATION (City, town or county) (State) Laytonsville, Maryland			
25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE Charles L. Kline					
DATE FEB 21 '62											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02031

CERTIFICATE OF DEATH

02013

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Surburban Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 3830 Harrison St. N.W.	
3. NAME OF DECEASED (Type or print) EMMA C. W. CORNELL		4. DATE OF DEATH Feb. 3 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years last birthday) 85
11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Monroe Wigginton		14. MOTHER'S MAIDEN NAME Elizabeth Crune	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Miss Mae Cornell, 3830 Harrison St. D.C.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cerebro Vascular Disease (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH 4 d.			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-4-62 , 19 62 , to 2-3 , 19 62 , that (I) (we) last saw the deceased alive on 2-2 , 19 62 , and that death occurred at 6:40 A.M., from the causes and on the date stated above.			
22a. SIGNATURE Wm Fleet Luckett		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William Fleet Luckett		22d. ADDRESS 5000 Reno Rd. N.W. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 2/4/1962	23c. NAME OF CEMETERY OR CREMATORY Resthaven Cemetery	23d. LOCATION (City, town or county) (State) Louisville, Ky.
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlers, Sons, WASHINGTON D.C.		25a. REC'D BY REGISTRAR DATE FEB 6 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon, papers, Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02032

02014

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dickerson d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dickerson d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) GRACE OLIVIA CROMWELL first Middle Last		4. DATE OF DEATH February 9 1962 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 13, 1879 B. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Joseph Hoyle		14. MOTHER'S MAIDEN NAME Annie Hoyle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO Richard Cromwell, Dickerson, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1949 , to Feb 9 1962 , that (I) (we) last saw the deceased alive on 8 Feb 1962 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John G. Fawcett M.D.		22b. DATE SIGNED Feb 13 '62	
22c. PHYSICIAN'S NAME (Type) John G. Fawcett		22d. ADDRESS Boys, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/12/62	
23c. NAME OF CEMETERY OR CREMATORY Monocacy		23d. LOCATION (City, town or county) (State) Beallsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William B. Hillon		25a. REC'D BY REGISTRAR DATE FEB 13 '62	
25b. REGISTRAR'S SIGNATURE Carroll S. Fawcett			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

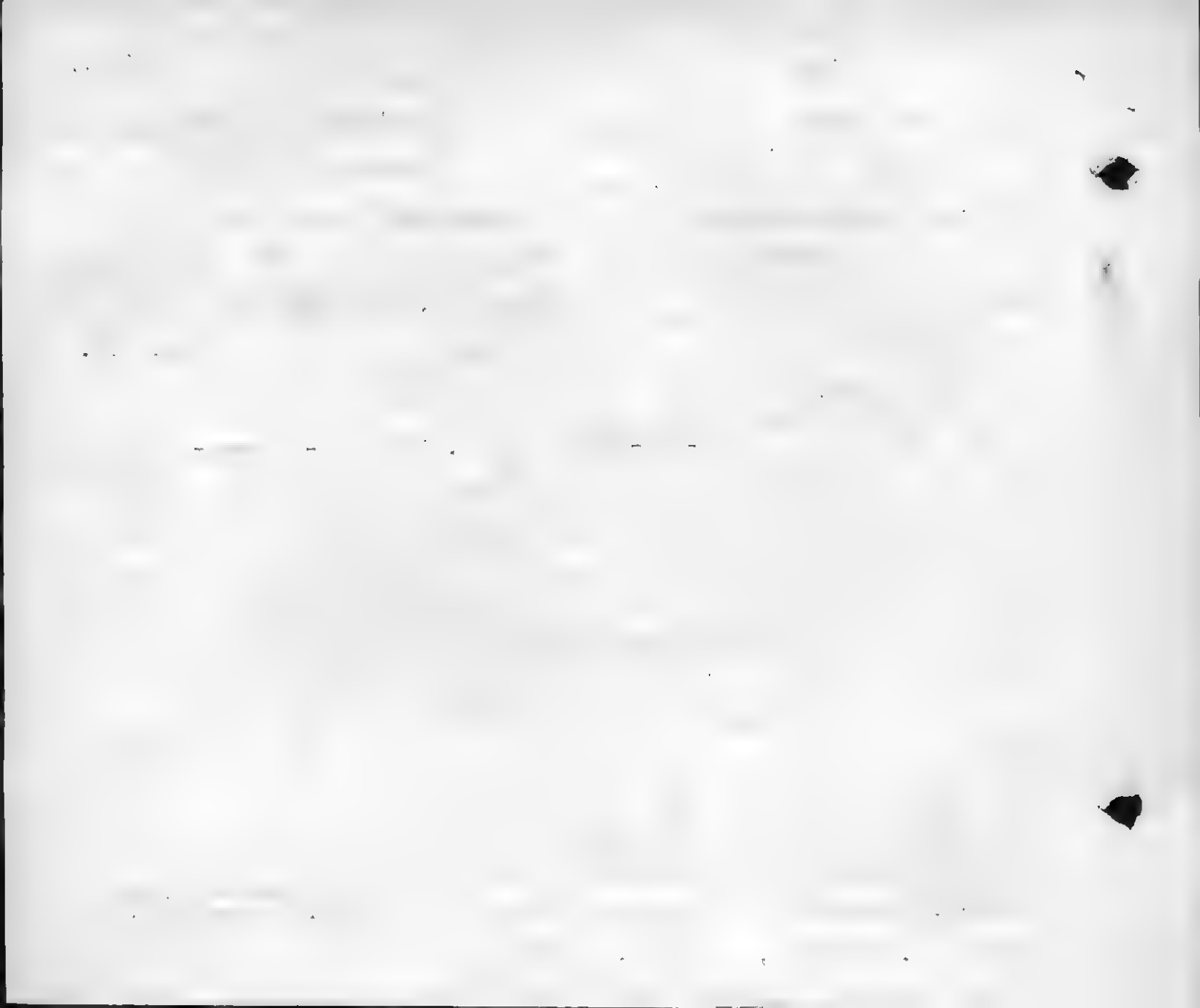
CERTIFICATE OF DEATH

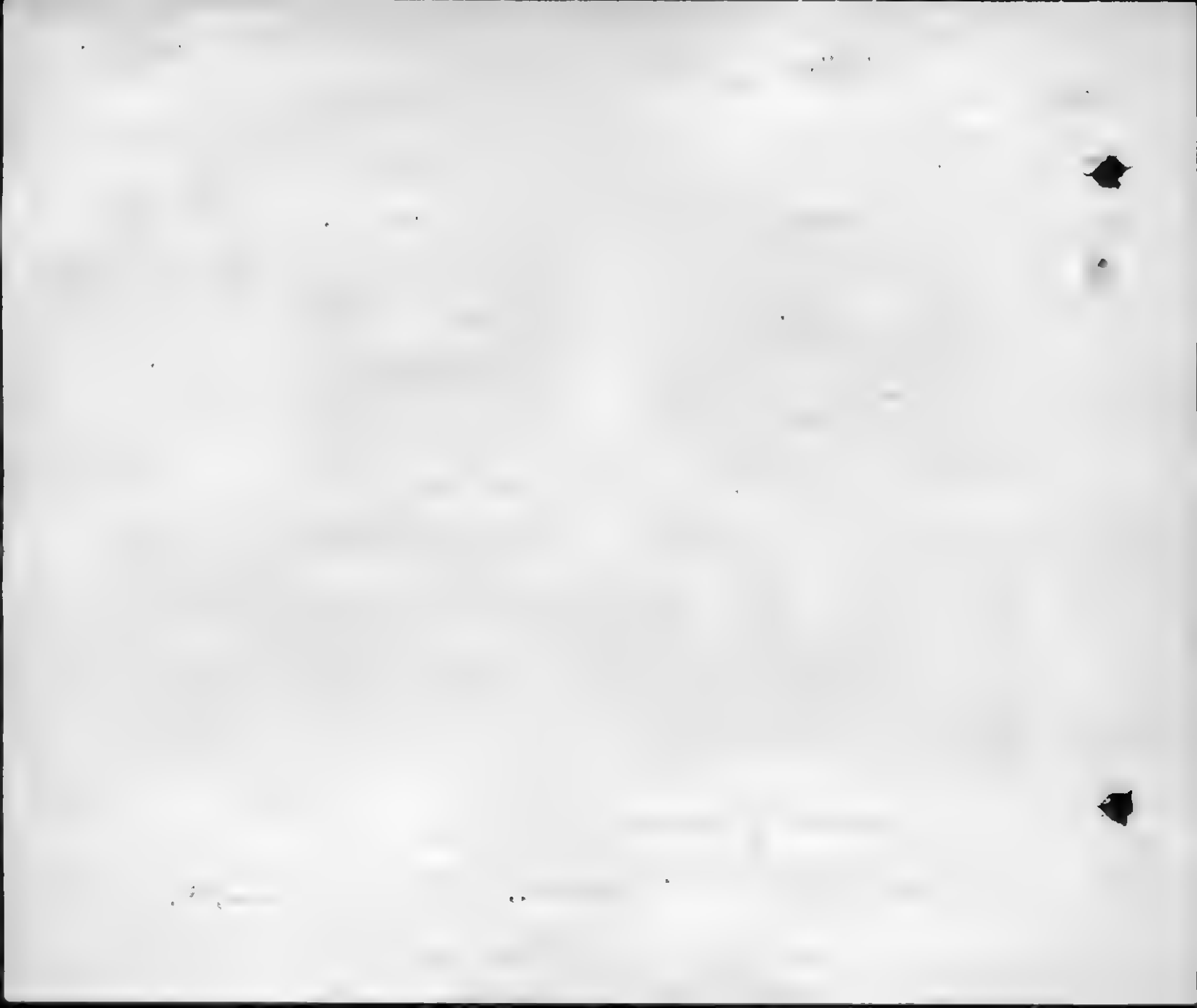
02033

Items 8-8-9 Film G507 2/13/62 iwk

02015

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 8202 Maple Ridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Josephine A Cywinski		4. DATE OF DEATH Month Feb		Day 1		Year 1962		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887	
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months 9		Days 12		Hours 		Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Poland		11. BIRTHPLACE (County & State, or Country) Poland	
12. CITIZEN OF WHAT COUNTRY? USA, Nat.		13. FATHER'S NAME Paul Radcka		14. MOTHER'S MAIDEN NAME Mary Ann		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 161-221-6304		17. INFORMANT John S. Cywinski-Husband-same 2d		Address 		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Paralysis 331 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Vascular accident (a), stating the underlying cause last. DUE TO (c) arteriosclerosis - cerebral generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) Repeated previous Cerebral Vascular accidents	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 		21. I certify that (I) (this hospital) attended the deceased from 12/3 19 59 to 2/1 19 62 that (I) (we) last saw the deceased alive on 2/1 19 62 and that death occurred at 1:50 PM from the causes and on the date stated above.	
22a. SIGNATURE OF PHYSICIAN Marcel J. Foret		22b. DATE SIGNED 2-2-62		22c. PHYSICIAN'S NAME (Type) MARCEL J. FORET		22d. ADDRESS 1746 K & NW Wash DC		22e. ATTENDING PHYS. <input checked="" type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/>		22g. STAFF PHYS. <input type="checkbox"/>		22h. LOCATION (City, town or county) (State) Mill Creek Township Erie, Pennsylvania	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		23b. DATE THEREOF 2/6/62		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town or county) (State) Mill Creek Township Erie, Pennsylvania		24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24b. ADDRESS 		25a. REC'D BY REGISTRAR DATE FEB 5 '62		25b. REGISTRAR'S SIGNATURE Charles S. Hester	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02035

02017

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>37 days.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 15</u> d. STREET ADDRESS <u>4805 Cumberland Avenue.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Irving Maxwell Day</u>		4. DATE OF DEATH Month Day Year <u>Feb. 25th. 19 62</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/1/94</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Engineer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Maxwell Warren Day</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES 1914-18</u>		16. SOCIAL SECURITY NO. <u>577-44-8008</u>	
17. INFORMANT <u>Wife-Doris Day</u>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>LIVER</u> (a), stating the underlying cause last. DUE TO (c) <u>2 YRS</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>36 HRS</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN, 1953</u> , to <u>FEB</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/25</u> , 19 <u>62</u> , and that death occurred at <u>3:20</u> P.M. from the causes and on the date stated above.		22. SIGNATURE <u>[Signature]</u>	
23. PHYSICIAN'S NAME (Type) <u>LEO J. DONOVAN M.D.</u>		24. ADDRESS <u>BETH 14 MARYLAND</u>	
25. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		26. DATE THEREOF <u>2/28/62</u>	
27. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		28. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
29. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		30. REC'D BY REGISTRAR <u>DATE MAR 1 '62</u>	
31. REGISTRAR'S SIGNATURE <u>[Signature]</u>		32. DATE <u>DATE</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02036

02018

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>				d. STREET ADDRESS <u>7131 Sycamore Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ernest Luther Daymude</u>				4. DATE OF DEATH <u>Feb. 24 1962</u>			
5. SEX <u>Male</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>April 29, 1895</u>			
9. AGE (in years last birthday) <u>67</u>				10. AGE (in years last birthday) <u>67</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Daymude</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cornelius Butt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>218-16-0421</u>			
17. INFORMANT <u>Jean C. Daymude</u>				Address <u>7131 Sycamore Ave, Tak.Pk, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Thrombosis</u> (c) <u>sudden</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brochart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-27-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Rockville Montgomery Co, Md.</u>			
23. FUNERAL DIRECTOR <u>Raymond A. Zisch</u>				24. REC'D BY REGISTRAR <u>Feb 28 '62</u>			
25. ADDRESS <u>34 Georgia Ave</u>				26. REGISTRAR'S SIGNATURE <u>William E. Pumphrey</u>			

VS. A15ME
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, for Page 1, 2, and 3 to the funeral home, and Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

02037

02019

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 15 <u>58 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>116 Meem Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>De Puy</u> Last <u>Do Puy</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>4th</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17-1904</u>
9. AGE (In years last birthday) <u>77</u> YES <input checked="" type="checkbox"/>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>17</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Justice of the Peace</u>	
11. BIRTHPLACE (State or foreign country) <u>Amitville L. I. N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Talbot De Puy</u>		14. MOTHER'S MAIDEN NAME <u>Frances Moffett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>U.S. Army. 1910.</u>		16. SOCIAL SECURITY NO <u>000-00-0000</u>	
17. INFORMANT <u>Dorothy De Puy</u>		Address <u>116 Meem Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> 502 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic Emphysema</u> DUE TO (c) <u>Chronic Bronchitis & Bronchectasis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.H.F. & anemia</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>72 hr</u> <u>10 yrs</u> <u>20 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/1/1954</u> to <u>2/4/1962</u> that (I) (we) last saw the deceased alive on <u>2/4/1962</u> and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Stephen H. Jones</u>		22b. DATE SIGNED <u>2/4/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen H. Jones</u>		22d. ADDRESS <u>809 Viers Mill Rd. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Feb 6th 62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest O. Gardner</u>		25. REC'D BY REGISTRAR DATE <u>FEB 6 '62</u>	
ADDRESS <u>Gaithersburg</u>		25b. REGISTRAR'S SIGNATURE <u>W. S. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02038

02020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY (In days) <u>17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maine</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Fairfield</u> d. STREET ADDRESS <u>Forest Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Donald David Doak</u>		4. DATE OF DEATH Last <u>Doak</u> Month <u>February</u> Day <u>19</u> Year <u>1962</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 21, 1907</u> 9. AGE (In years) <u>54</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maine</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Richard E. Doak</u> 14. MOTHER'S MAIDEN NAME <u>Mary Nichols</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO (b) <u>Ventricular Fibrillation</u> DUE TO (c) <u>Immediate post-operative pericardiectomy for Constrictive Pericarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____			
19. INTERVAL BETWEEN ONSET AND DEATH <u>20 Minutes</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____		20c. TIME OF INJURY Month, Day, Year: _____ Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (this hospital) attended the deceased from <u>February 2, 1962</u> , to <u>February 19, 1962</u> , that (I) (we) last saw the deceased alive on <u>February 19, 1962</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. B. Berry</u> 22c. PHYSICIAN'S NAME (Type) <u>W. B. Berry</u>		22b. DATE SIGNED <u>February 20, 1962</u> 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u> 23b. DATE THEREOF <u>2-21-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u> 23d. LOCATION (City, town or county) <u>Ft. Fairfield, Maine</u> (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>FEB 23 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>		25c. NAME OF CEMETERY OR CREMATORY <u>Bethesda, Md.</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

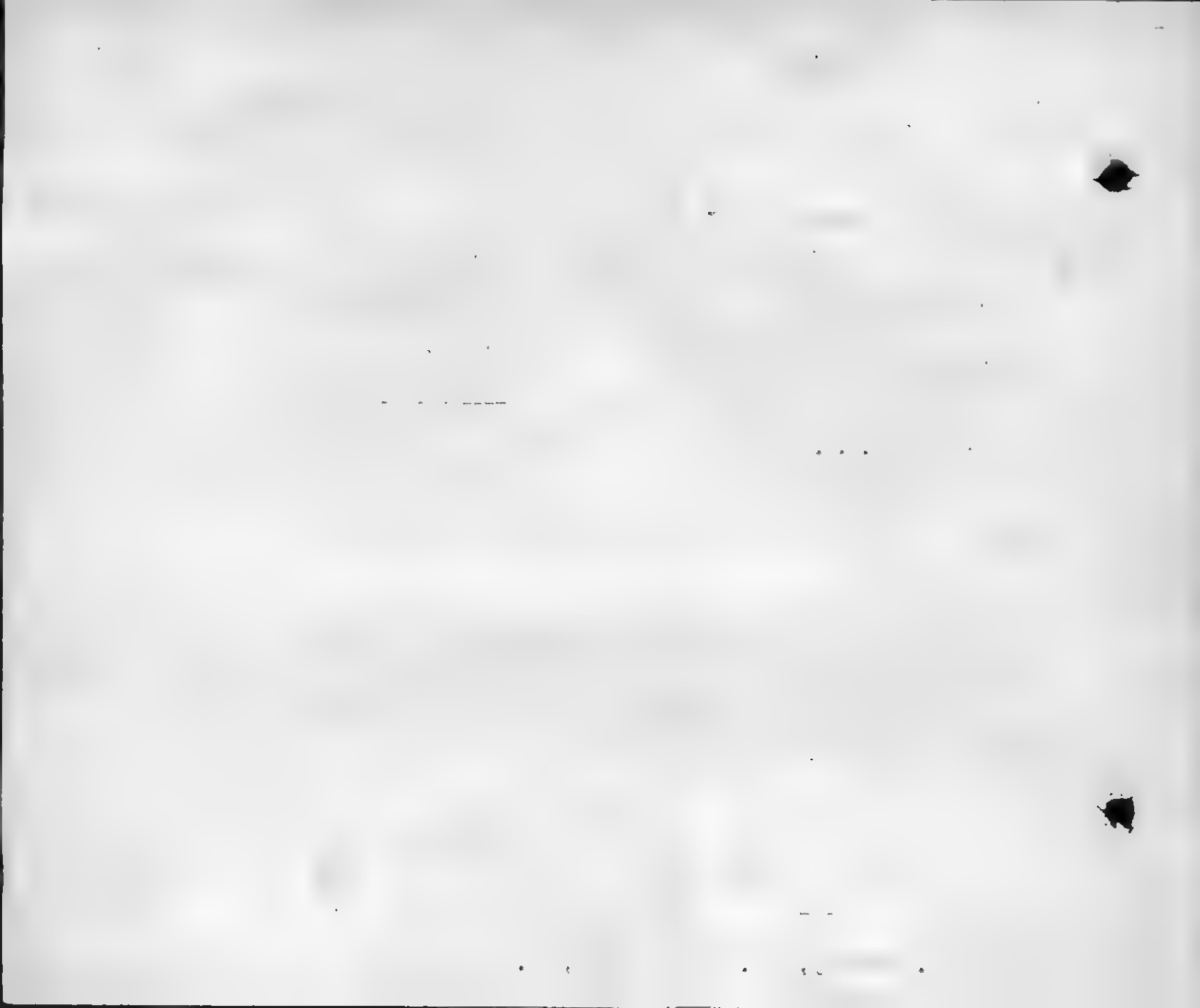
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02039

CERTIFICATE OF DEATH

02021

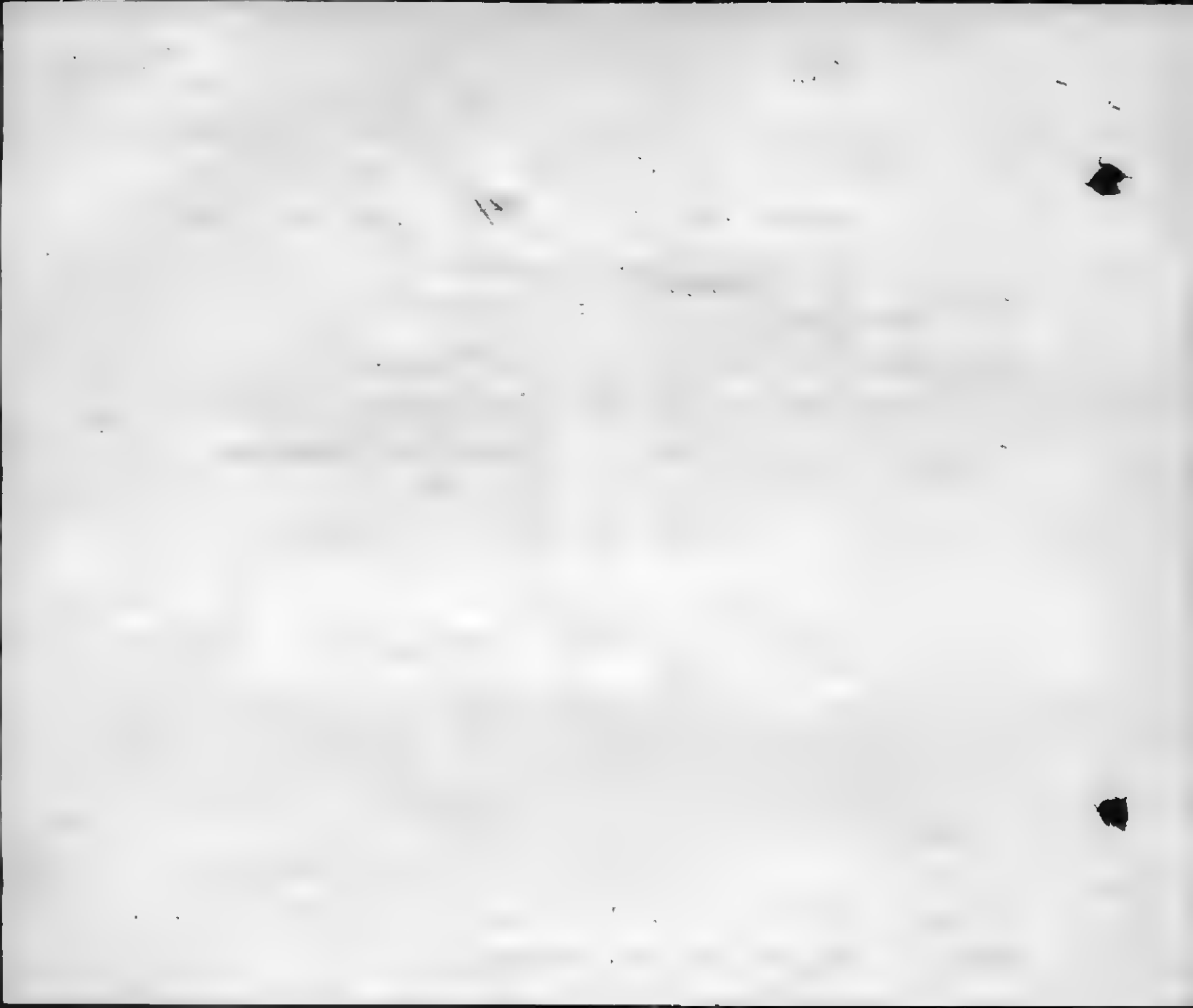
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town <u>Wheaton</u> c. LENGTH OF STAY IN b <u>2 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BELPKE Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11703 Highview Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Edward Dolan</u>		4. DATE OF DEATH <u>FEBRUARY 28 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>JANUARY 1, 1882</u>	9. AGE (In years, if under 1 year, last birthday) <u>80</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Mins <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Medical Doctor</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Dolan</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Cowey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes W.W.I.</u>		16. SOCIAL SECURITY NO. <u>Yes</u> 17. INFORMANT <u>Rosemary Dolan</u> Address <u>11703 Highview Ave. S.S.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> (c) <u>Moemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unknown</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Hour <u>19</u> s.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	20f. (City or town) <u>Wheaton</u> (County) <u>Montgomery</u> (State) <u>Md.</u>
21. I certify that (I) (this hospital) attended the deceased from August 22, 1961, to Feb 27, 1962, that (I) (we) last saw the deceased alive on Feb 27, 1962, and that death occurred at 12:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Michael Madeloff</u> M.D.		22b. DATE SIGNED <u>Feb 28, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>MICHAEL MADELOFF M.D.</u>		22d. ADDRESS <u>11406 Viers Mill Rd Wheaton Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-2-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	23d. LOCATION (City, town or county) <u>Arlington</u> (State) <u>Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Warner</u>		25a. REC'D BY REGISTRAR <u>E. Pumphrey, Inc. Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>John S. Kinn</u>		DATE <u>2 '62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02040
02022

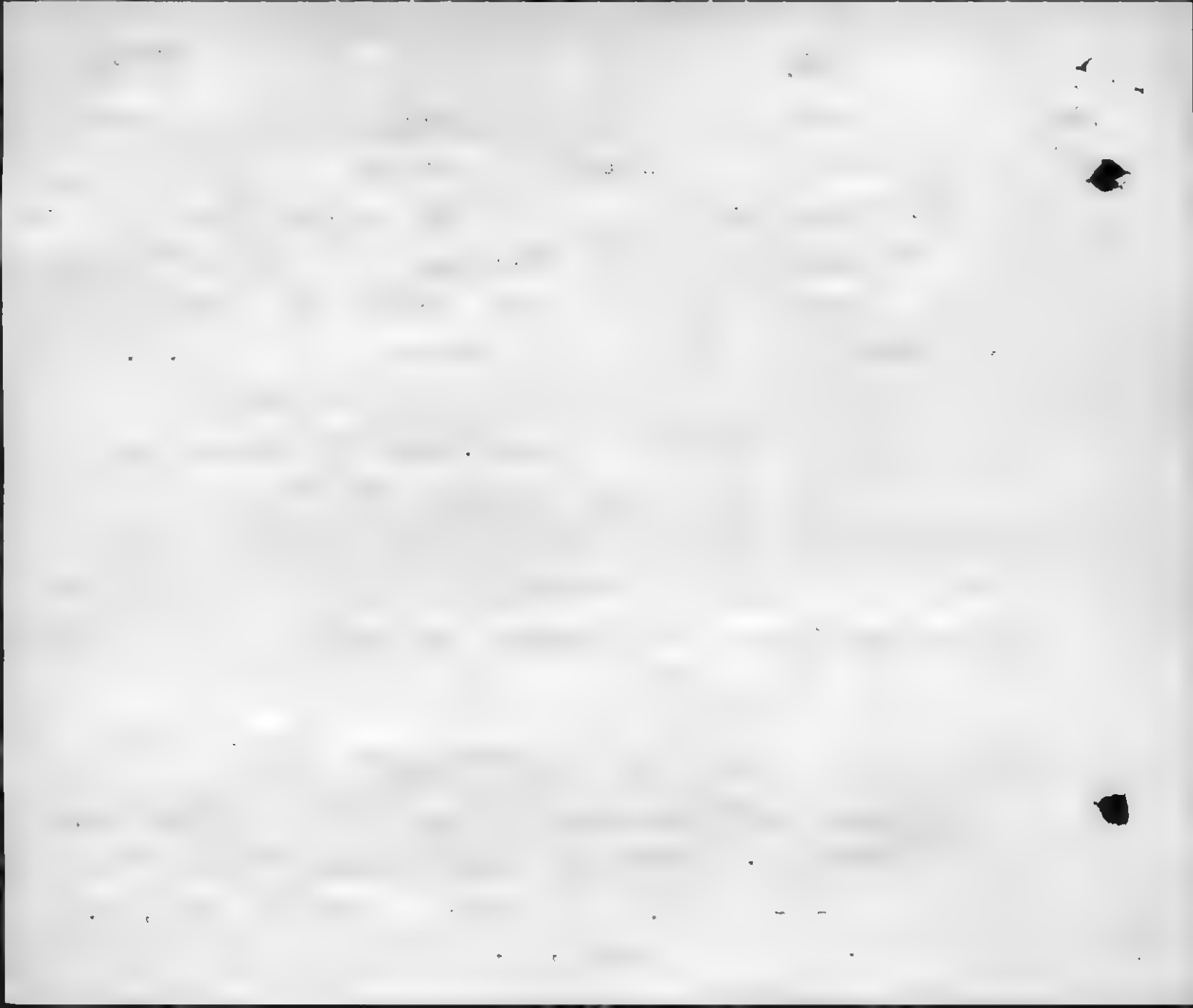
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda/Day No.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		e. STREET ADDRESS <i>4610 - Norwood Drive</i>	
3. NAME OF DECEASED (Type or print) <i>Walter Hysius Howard</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>28</i> Year <i>1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>8/25/88</i>
9. AGE (In years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR Months <i>13</i> Days <i>13</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>reg. lumber trader private Maryland</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Charles Howard</i>		14. MOTHER'S MAIDEN NAME <i>Marj Christine Leach</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown-Yes</i>	
17. INFORMANT <i>Charles F. Howard</i>		Address <i>4027 Oliver</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Cerebral arteriosclerosis</i> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDIT ON GIVEN IN PART I (a)) <i>Severe chronic pulmonary emphysema & partial pneumothorax (left)</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 28, 1962</i> to <i>Feb 28, 1962</i> , that (I) (we) last saw the deceased alive on <i>Feb 28, 1962</i> and that death occurred at <i>9:45</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>George A. Gray, Jr.</i>		22b. DATE SIGNED <i>3/1/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>GEORGE A. GRAY, JR. M.D.</i>		22d. ADDRESS <i>4740 Chevy Chase Dr., Mont. Co. Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>3/3/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Washington, D. C.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		25a. REC'D BY REGISTRAR <i>WAR 5 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>S. Harris</i>		25c. ADDRESS <i>Bethesda, Maryland</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02041 CERTIFICATE OF DEATH 02023

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 11 Months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8605 Bradmoor Drive		2. USUAL RESIDENCE (Where deceased lived, if not full on: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8605 Bradmoor Drive	
3. NAME OF DECEASED (Type or print) RICHARD F. ELGIN, Sr. 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Feb. 14 1962 8. DATE OF BIRTH Apr 12, 1881 9. AGE (in years last birthday) 80 yrs. IF UNDER 1 YEAR Months 10 Days 2 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Dealer 10b. KIND OF BUSINESS OR INDUSTRY Retired 11. BIRTHPLACE (County & State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Luther Elgin 14. MOTHER'S MAIDEN NAME Elizabeth Bottler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Wife Address Same as Item #2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Dissecting aneurysm of the abdominal aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerosis (c) Coronary sclerosis — Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour 5:55 p.m. 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Yuma 5557p M.D. Frederick County, Md.	
21. I certify that (I) (this hospital) attended the deceased from June 1961 to Feb 14, 1962 , that (I) (we) last saw the deceased alive on Feb 14, 1962 , and that death occurred at 5:55 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Malcolm D. Harrison M.D. 22c. PHYSICIAN'S NAME (Type) MALCOLM D. HARRISON		22b. DATE SIGNED Feb. 14, 1962 22d. ADDRESS 4535 Yuma St NW - Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-17-62		23c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery 23d. LOCATION (City, town or county) (State) Frederick County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR FEB 19 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Krum	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02042

CERTIFICATE OF DEATH

02024

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Massachusetts</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wilbraham</u> d. STREET ADDRESS <u>34 Oakland St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Judith Lloyd Ellicott</u>		4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-17-34</u> 9. AGE (In years last birthday) <u>27</u> yrs. IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin B. Barger</u> 14. MOTHER'S MAIDEN NAME <u>Helen Nicols</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Charles Raymond Ellicott, III.</u> Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> (b) <u>Nephritis</u> (c) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last: PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus - Brittle</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs ±</u> <u>2 yrs ±</u> <u>6 wks</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u>2-5-1962</u> Hour <u>2:51</u> e.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>2/5/1962</u> to <u>2/7/1962</u> , that (I) last saw the deceased alive on <u>2-7-1962</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Robert A. Hare M.D.</u> 22b. ADDRESS <u>7600 Carroll Ave. T.P., Md.</u> 22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u> 22d. ADDRESS <u>7600 Carroll Ave. T.P., Md.</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2-10-1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S CHURCH CEMETERY, Chestertown, MD.</u> 23d. LOCATION (City, town or county) <u>—</u> (State) <u>—</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph G. Gwinn</u> 25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>—</u> 25c. DATE <u>FEB 13 '62</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

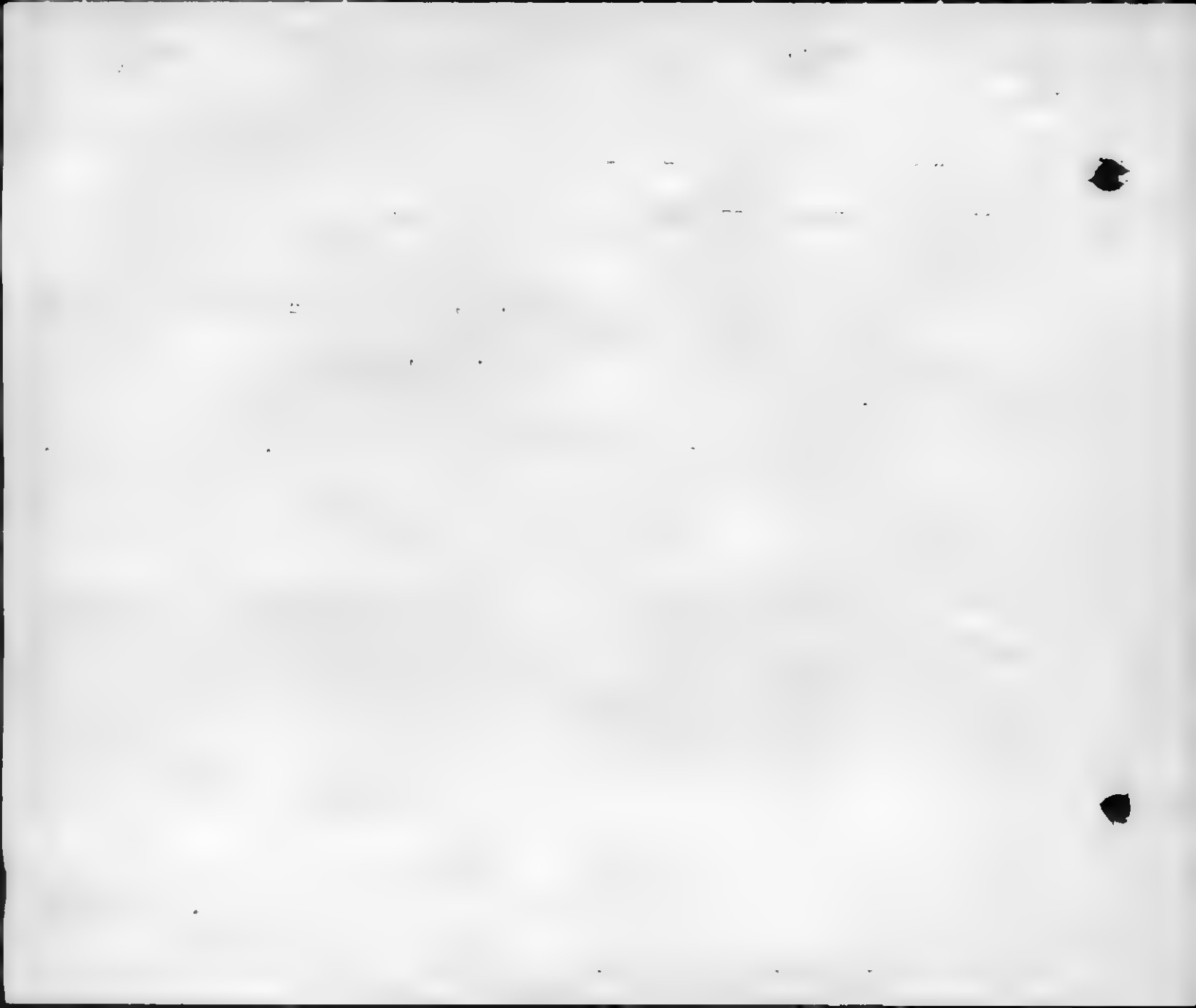
02043

02025

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Silver Spring</u> c. LENGTH OF STAY (If not in hospital, give street address) <u>7 year 2 hr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8600 16th Street</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN Philip</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 25, 1911</u> 9. AGE (In years last birthday) <u>55 yrs.</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>11 19 62</u>		4. DATE OF DEATH <u>2 11 1962</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Merchandising</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>St. Paul, Minnesota</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Homer A. Evans</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>075-03-4756</u> 17. INFORMANT <u>Frank Cady</u> Address <u>8600 16th St. Silver Spring, Md.</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Atkins</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUETO <u>Coronary sclerosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. <u>1-0-1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>1 year</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Utica</u> (County) <u>Oneida Co.</u> (State) <u>New York</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 15, 1961</u> to <u>February 11, 1962</u> that (I) (we) last saw the deceased alive on <u>2/11/1962</u> and that death occurred at <u>9:40 AM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Max G. Sherer</u> 22b. DATE SIGNED <u>2/11/62</u> 22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER, MD</u> 22d. ADDRESS <u>2025 EAST West Hwy Silver Spring, Md</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-15-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u> 23d. LOCATION (City, town or county) <u>Utica</u> (State) <u>New York</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumping</u> 25a. REC'D BY REGISTRAR <u>Raymond Q. Ziska</u> 25b. REGISTRAR'S SIGNATURE <u>DATE FEB 15 '62</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02045

02027

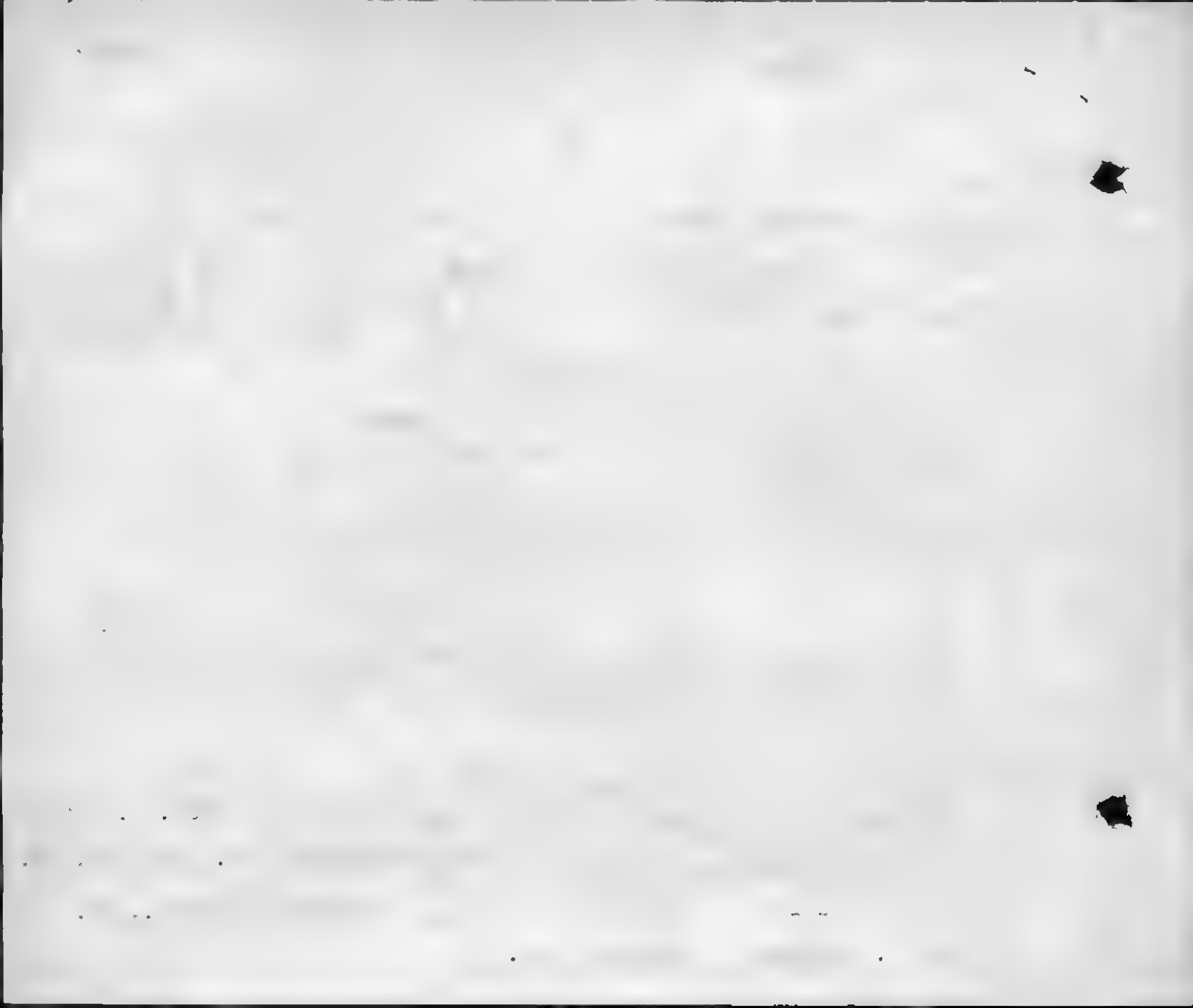
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake Beach d. STREET ADDRESS R.R. #1	
3. NAME OF DECEASED (Type or print) Sally Owen Fitzhugh		4. DATE OF DEATH Month February Day 1 Year 1962	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 SEPT 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.
11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ambrose Collins		14. MOTHER'S MAIDEN NAME Betty Sublette	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 407-18-9661A	
17. INFORMANT HUS: Clark S. Fitzhugh, Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Occlusive arteriosclerotic vascular disease DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that the (this hospital) attended the deceased from Jan. 28, 1962 to Feb. 1, 1962 that the (we) last saw the deceased alive on Feb. 1, 1962 , and that death occurred at 8:00 PM from the causes and on the date stated above.			
22a. SIGNATURE C.W. Bramlett		22b. DATE SIGNED February 1, 1962	
22c. PHYSICIAN'S NAME (Type) C.W. BRAMLETT, LCDR MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 5 Feb 1962	23c. NAME OF CEMETERY OR CREMATORY Cedar Hills	23d. LOCATION (City, town or county) Prince George's Maryland
24. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines Co.		25a. REC'D BY REGISTRAR FEB 5 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02046
02028
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>7113 46th Street</u>	
3. NAME OF DECEASED (Type or print) <u>John W. Fletcher</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 9, 1875</u>
9. AGE (In years last birthday) <u>87</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder (retired) Building</u>	11. BIRTHPLACE (County & State, or foreign country) <u>London, Ontario, Canada</u>	12. CITIZEN OF WHAT COUNTRY? <u>Naturalized</u>
13. FATHER'S NAME <u>John Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Melissa Elliott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>SEN</u>	
17. INFORMANT <u>Robert E. Fletcher</u>		Address <u>441 W. 1st St. N.E.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Confluent bronchopneumonia, bilateral</u> Conditions, if any, which gave rise to immediate cause (b) <u>late</u> (c) <u>2 wks.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the physician) attended the deceased from <u>Feb. 20</u> , 19 <u>62</u> to <u>Feb. 28</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>Feb. 27</u> , 19 <u>62</u> and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Wadler</u>		22b. DATE SIGNED <u>Mar. 1, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d. ADDRESS <u>8218 Wisconsin Ave., Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-3-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Montgomery County, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 5 '62</u>	
ADDRESS <u>Bethesda, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>James S. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02029

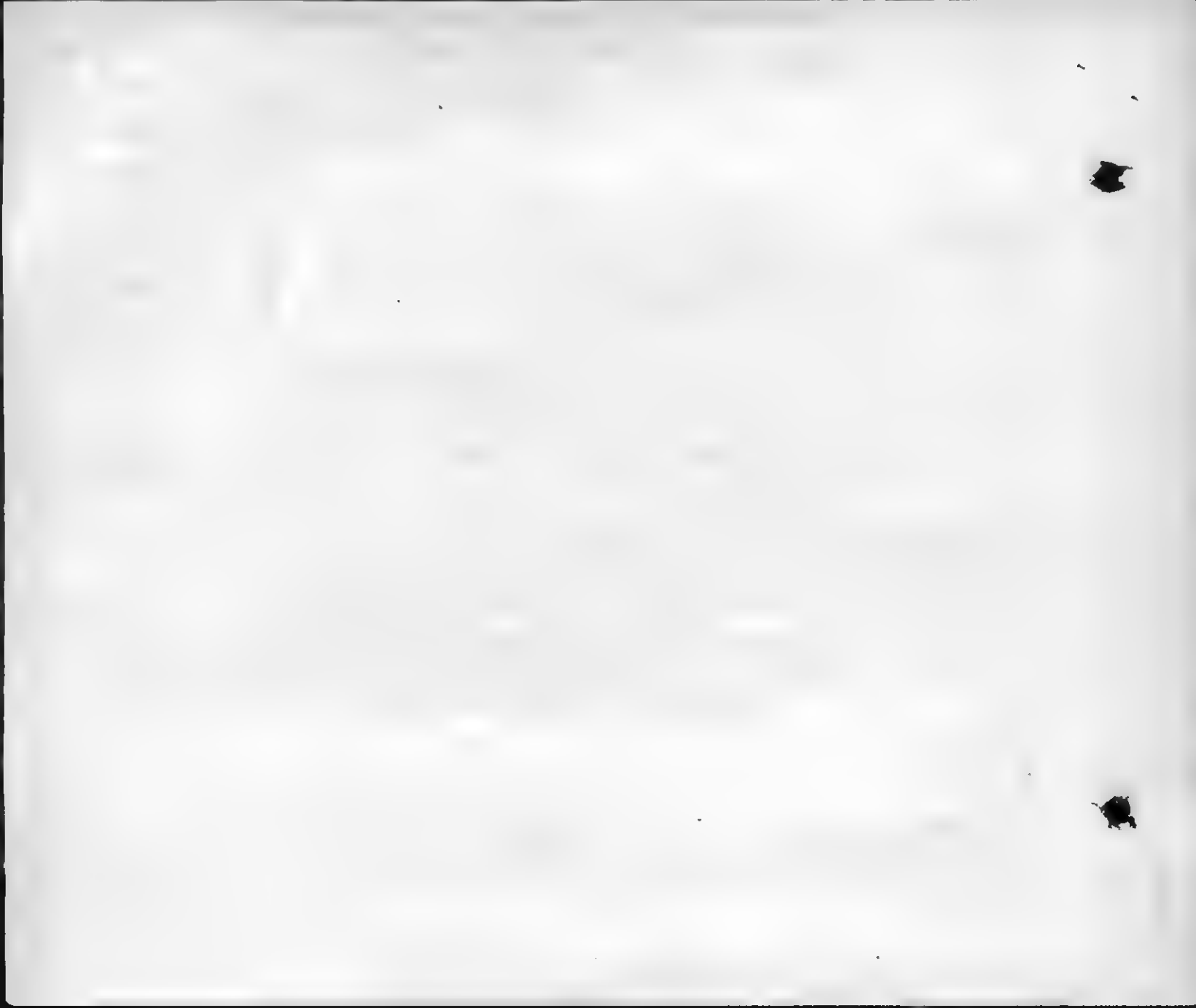
02047

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>31 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8034 Park Lane</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>RALPH WALDO FOSTER</u>		4. DATE OF DEATH <u>Feb 13 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1, 1898</u>
9. AGE (In years last birthday) <u>63 1/2</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (If deceased was engaged in occupation during most of working life, even if retired) <u>Executive Secretary YMCA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>YMCA</u>	
11. FATHER'S NAME <u>John Foster</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. MOTHER'S MAIDEN NAME <u>Stella Gross</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>578-46-0240</u>	
17. INFORMANT <u>THELMA FOSTER - wife - 8034 Park Lane</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>420</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Acute Coronary thrombus</u> DUE TO <u>Atherosclerosis</u> (c) <u>Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u> <u>Chronic</u> <u>Chronic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>Feb. 13</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>62</u> , and that death occurred at <u>1:59 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. W. Nicklas</u> M.D.		ADDRESS (Street, city or town, state) <u>4830 - V St. N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD W. NICKLAS</u>		DATE SIGNED <u>2/13/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/16/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 15 '62</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

Coroner Notified + Approved.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

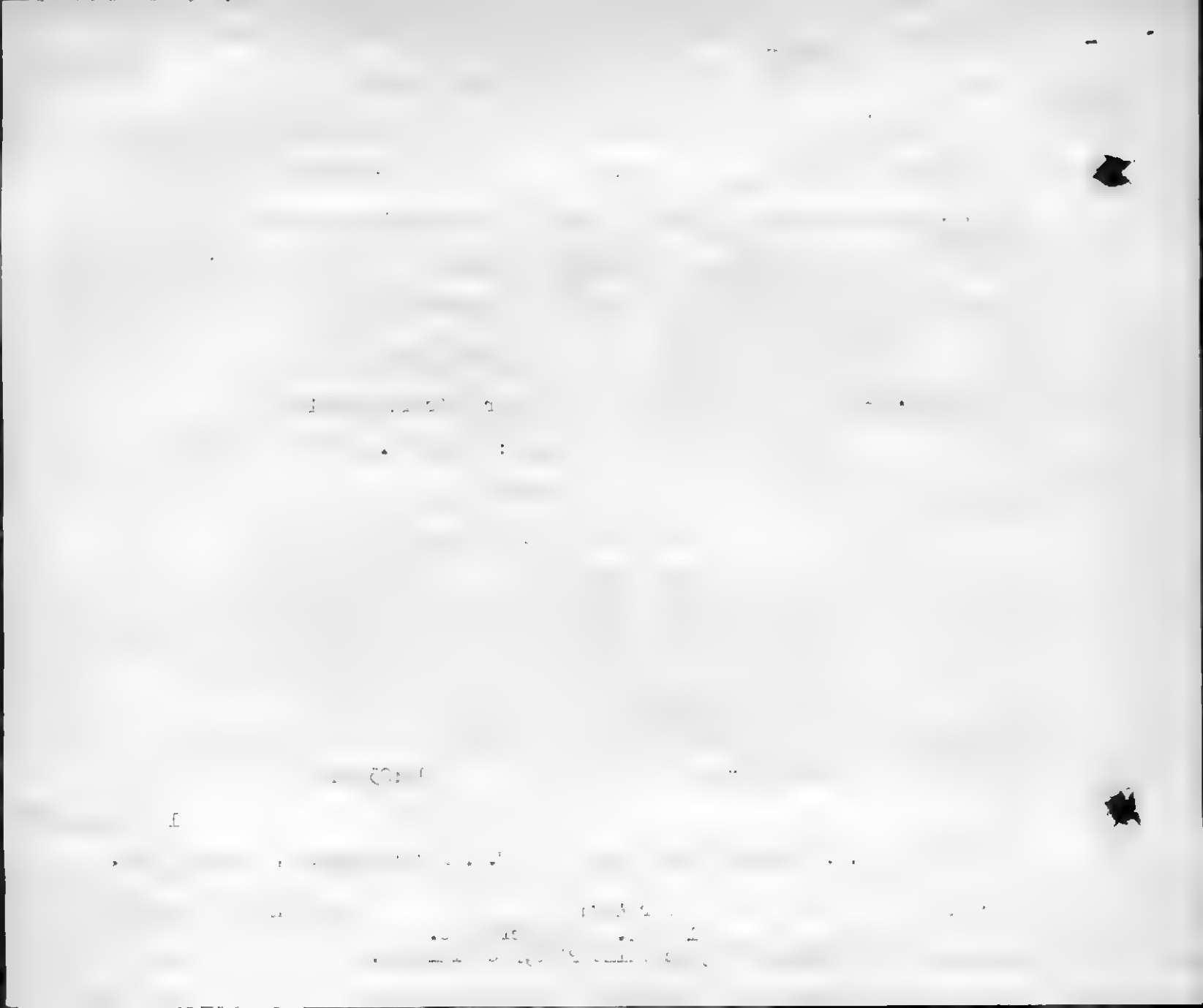
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02048

02030

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville, Maryland</u> d. STREET ADDRESS <u>13203 Parkland Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Malcolm FRYE</u> 4. DATE OF DEATH <u>February 17 1962</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Cauc</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>22 November 1956</u> 9. AGE (in years last birthday) <u>5</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>California</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>California</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Samual M. Frye</u> 14. MOTHER'S MAIDEN NAME <u>Mary Virginia Davis</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Same as #2</u> 16. SOCIAL SECURITY NO. <u>Father: Samual M. Frye</u> 17. INFORMANT <u>Same as #2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular pneumonia</u> DUE TO (b) <u>Acute Lymphatic leukemia in remission</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <u></u> at work <u></u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		21. I certify that (a) (this hospital) attended the deceased from <u>15 February 1962</u> to <u>17 February 1962</u> , that (b) (we) last saw the deceased alive on <u>17 February 1962</u> , and that death occurred at <u>10:25 AM</u> the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
22a. SIGNATURE <u>H.A. PEARSON, LCDR MC USN</u> 22c. PHYSICIAN'S NAME (Type) <u>H.A. PEARSON, LCDR MC USN</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Md.</u>		22b. DATE SIGNED <u>17 February 62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>20 Feb 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u> 23d. LOCATION (City, town or county) <u>Rockville</u> (State) <u>Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> <u>1331 E. Montgomery Ave.</u> REC'D BY REGISTRAR <u>FOR 21 '62</u> 25b. REGISTRAR'S SIGNATURE <u>C. S. Kraus</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02049

02031

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN TB 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney d. STREET ADDRESS none e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Edward Gaither		4. DATE OF DEATH Month February Day 4 Year 1962	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> unknown	8. DATE OF BIRTH 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY Maryland	12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME James Gaither		14. MOTHER'S MAIDEN NAME Kathryn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO (b) Chronic Myocarditis & Arricular fibrillation DUE TO (c) Hypertensive Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 2/3/62 to 2/4/62 , that (I) (we) last saw the deceased alive on 2/3/62 , and that death occurred 2/4/62 from the causes and on the date stated above. 22a. SIGNATURE Charles H. Ligon 22b. DATE SIGNED 2/4/62 22c. PHYSICIAN'S NAME (Type) Charles H. Ligon 22d. ADDRESS Sandy Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 2/7/62		23b. DATE THEREOF 2/7/62	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion.,		23d. LOCATION (City, town or county) (State) Mt. Zion, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodden		25a. REC'D BY REGISTRAR DATE FEB 13 1962	
25b. REGISTRAR'S SIGNATURE W. M. D. Thomas			

II

f. 1.

f. 2.

f. 3.

f. 4.

f. 5.

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f. 17. f. 18.

f. 19. f. 20.

f. 21. f. 22.

f. 23. f. 24.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02050

02032

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Wheaton</u> c. LENGTH OF STAY IN (If not in hospital, give street address) <u>5 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bel Air Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>601 Tuckerman St. N.W.</u>									
3. NAME OF DECEASED (Type or print) <u>Sarah Jane Garden</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1962</u>									
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 22, 1874</u>								
9. AGE (In years last birthday) <u>87</u> yrs. <table border="1"> <tr> <th colspan="2">F UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		F UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
F UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
11. BIRTHPLACE (County & State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Charles V. Sherwood</u>		14. MOTHER'S MAIDEN NAME <u>Emma F. Bladen</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Anna E. Matter</u>									
17. INFORMATION <u>601 Tuckerman St. N.W.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> (b) <u>arteriosclerotic heart disease</u> (c) <u>carcinoma of breast</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>carcinoma of breast</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>20 yrs</u>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 21, 1962</u> to <u>Feb 21, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 21, 1962</u> and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>N.F. Kreuzburg</u>		22b. DATE SIGNED <u>2/21/62</u>									
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>7852 16th St. N.W. Wash. D.C.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/24/62</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>FEB 23 '62</u>									
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. ADDRESS									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02051

Item 9 Film G307

CERTIFICATE OF DEATH

02033

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN It <u>33 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>X</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3819 Calvert Street, N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>C.</u> Last <u>Germano</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 17, 1883</u> 9. AGE (In years last birthday, yrs. <u>78</u> 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> 11. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>7</u>		4. DATE OF DEATH <u>February 17, 1962</u> 9. AGE (In years last birthday, yrs. <u>78</u> 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> 11. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired marble cutter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>private</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Un Known</u> 14. MOTHER'S MAIDEN NAME <u>Un Known</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Un Known</u> 16. SOCIAL SECURITY NO. <u>578-07-6281</u> 17. INFORMANT <u>Ira S. Lawyer</u> Address <u>3819 Calvert St N.W. City.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial failure, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>convalescent coronary infarction</u> (c) <u>coronary sclerosis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>anular carcinoma, descending colon</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u> 20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State) <u>D.C.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 17, 1962</u> to <u>Feb 17, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 17, 1962</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James A. Cannon Jr</u> 22c. PHYSICIAN'S NAME (Type) <u>JAMES A. CANNON JR</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>3141 34th St N.W. Wash. D.C.</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>20 Feb. 1962</u> 23b. DATE THEREOF <u>20 Feb. 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NAT. Cem.</u> 23d. LOCATION (City, town or county) <u>MARYLAND</u> (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don Ruff</u> ADDRESS <u>2224 Wise Ave. N.W.</u> 25a. REC'D BY REGISTRAR <u>FEB 23 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Carlton S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



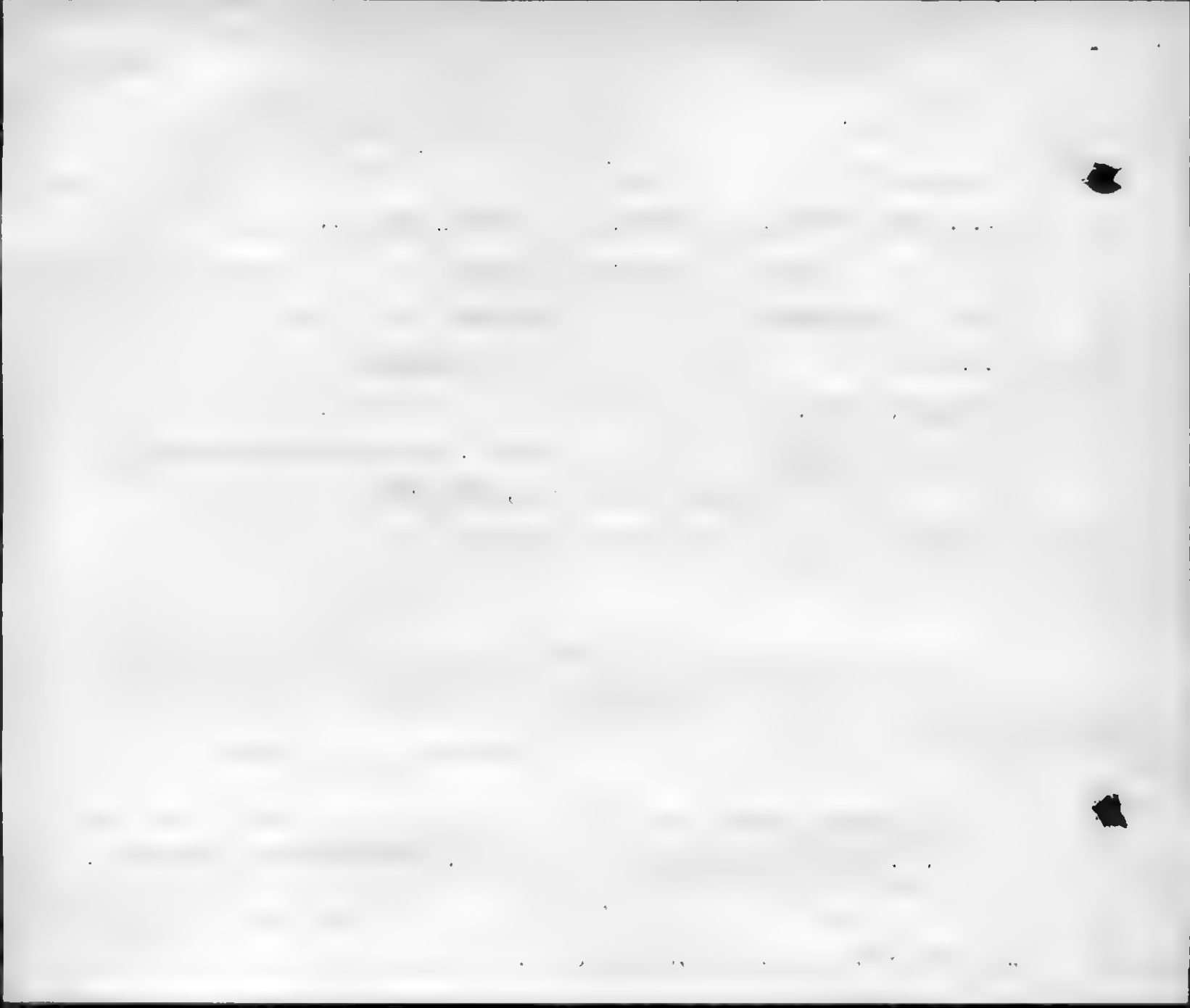
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15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02052 CERTIFICATE OF DEATH 02034

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 41 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland		b. COUNTY Hyattsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 5400 42nd Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John William Gessner		4. DATE OF DEATH February 8 1962		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 October 1875		9. AGE (in years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GESSNER, John M.		14. MOTHER'S MAIDEN NAME FITZMAURICE, Mary		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes S-A and WWI		16. SOCIAL SECURITY NO. 1-23-12-62		17. INFORMANT Bernard F. GESSNER (SON) Same as #2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis acute, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Infection - Myocardium DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21. I certify that (X) (this hospital) attended the deceased from 30 December, 1961 to 8 February, 1962 that (X) (we) last saw the deceased alive on 8 February 1962, and that death occurred at 1:48 PM from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (X) (this hospital) attended the deceased from 30 December, 1961 to 8 February, 1962 that (X) (we) last saw the deceased alive on 8 February 1962, and that death occurred at 1:48 PM from the causes and on the date stated above.		22a. SIGNATURE W. F. WARRENDER		22b. DATE SIGNED 9 Feb. 1962		22c. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA MD.		22d. DATE 13 '62		22e. REGISTRAR'S SIGNATURE John Taylor		22f. REGISTRAR'S SIGNATURE John Taylor							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-12-62		23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town or county) (State) West St., Annapolis Maryland		23e. REC'D BY REGISTRAR John Taylor		23f. REGISTRAR'S SIGNATURE John Taylor		23g. REGISTRAR'S SIGNATURE John Taylor		23h. REGISTRAR'S SIGNATURE John Taylor					



02053

CERTIFICATE OF DEATH

Reg. Dist. No.

02035

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution—Residence before admission) o STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY in 1b <u>5 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SEABOARD HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JANE</u> Middle <u>A.</u> Last <u>GIBBONS</u>				4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/16/85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>76</u> yrs		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>	
13. FATHER'S NAME <u>JOHN REED</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME <u>BRIDGET HANSBURY</u>			
16. SOCIAL SECURITY NO. <u>579-40-6090B</u>				17. INFORMANT <u>John Mc. Innamary</u> Address <u>7110 Belmont Rd. Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>HYPERTENSION</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS; UREMIA</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>FEB. 22</u> , 19 <u>62</u> , to <u>FEB. 26</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>FEB. 26</u> , 19 <u>62</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Joseph D. Connor</u> M.D.				ADDRESS (Street, city or town, state) <u>9420 Old Georgetown Road, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Joseph D. Connor, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 1-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821-14th St. N.W., Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 28 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Stone</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02054

02036

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN b 18 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanatorium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE District of Columbia
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 1041 Newton Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Antoinette Middle Elizabeth Last Grady
4. DATE OF DEATH February 6, 1962
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH December 5, 1887 9. AGE (in years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - National Geographic
10b. KIND OF BUSINESS OR INDUSTRY District of Columbia
11. BIRTHPLACE (County & State, or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Kelly
14. MOTHER'S MAIDEN NAME Eda Geier

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No
16. SOCIAL SECURITY NO. 579-48-80
17. INFORMANT Washington Sanatorium and Hospital Address to funeral

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
420.0 DUE TO congestive failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive failure DUE TO (c) congestive failure
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) congestive failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 19, 1961 to Feb 6, 1962, that (I) (we) last saw the deceased alive on Feb 5, 1962, and that death occurred at 2:15 P.M. from the causes and on the date stated above.
22a. SIGNATURE Boris Rabkin M.D.
22b. DATE SIGNED 2/6/62
22c. PHYSICIAN'S NAME (Type) BORIS RABKIN
22d. ADDRESS 1019 University Blvd East, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/9/62
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln
23d. LOCATION (City, town or county) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Kalley's Funeral Home, Inc. ADDRESS 1111 Rainer Rd.
25a. REC'D BY REGISTRAR DATE FEB 8 '62
25b. REGISTRAR'S SIGNATURE William S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 FOR STATE HEALTH DEPT. M 49 2 8 TO DEPUTY CAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02055 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02037

<p>1. PLACE OF DEATH</p> <p>a. COUNTY Montgomery</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)</p> <p>c. LENGTH OF STAY IN 1b DOA</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE Virginia</p> <p>b. COUNTY Fredericksburg</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 215 Frazier Street</p> <p>d. STREET ADDRESS 215 Frazier Street</p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print)</p> <p>First Elwood Middle Nathan Last Gray</p>		<p>4. DATE OF DEATH</p> <p>Month February Day 25 Year 1962</p>		
<p>5. SEX male</p>	<p>6. COLOR OR RACE Negro</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH September 7, 1941</p>	<p>9. AGE (In years last birthday) 20 yrs.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) Hustle, Virginia</p>
<p>12. CITIZEN OF WHAT COUNTRY? USA</p>		<p>13. FATHER'S NAME James Hyland Gray</p>		
<p>14. MOTHER'S MAIDEN NAME Susie Anna (Maiden name unknown)</p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes</p>		
<p>16. SOCIAL SECURITY NO. 228-50-0491</p>		<p>17. INFORMANT Marine Corps Records</p>		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Subdural hemorrhage</p> <p>DUPLICATE 825X</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Central hemorrhage + laceration</p> <p>DUPLICATE fracture of skull - auto accident</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>				
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>				
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto involved in accident</p>				
<p>20c. TIME OF INJURY</p> <p>Month, Day, Year 2-25-62</p> <p>Hour a.m. 1:00</p>		<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></p>		
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) US 301, 1 mile N. of Port Royal Va., King George, Va.</p>		<p>20f. (City or town) Port Royal (County) King George (State) CO.</p>		
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>				
<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>				
<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>				
<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>				
<p>DATE SIGNED 25 February 1962</p>				
<p>Address (Street, city, town, or county) Gaithersburg, Maryland</p>				
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>				
<p>22b. DATE THEREOF 3-2-62</p>				
<p>22c. LOCATION (City, town, or county) Champlain, Va.</p>				
<p>23. FUNERAL DIRECTOR Edwards Funeral Home, Bowling Green, Va.</p>				
<p>24a. REC'D BY REGISTRAR MAR 5 '62</p>				
<p>24b. REGISTRAR'S SIGNATURE</p>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

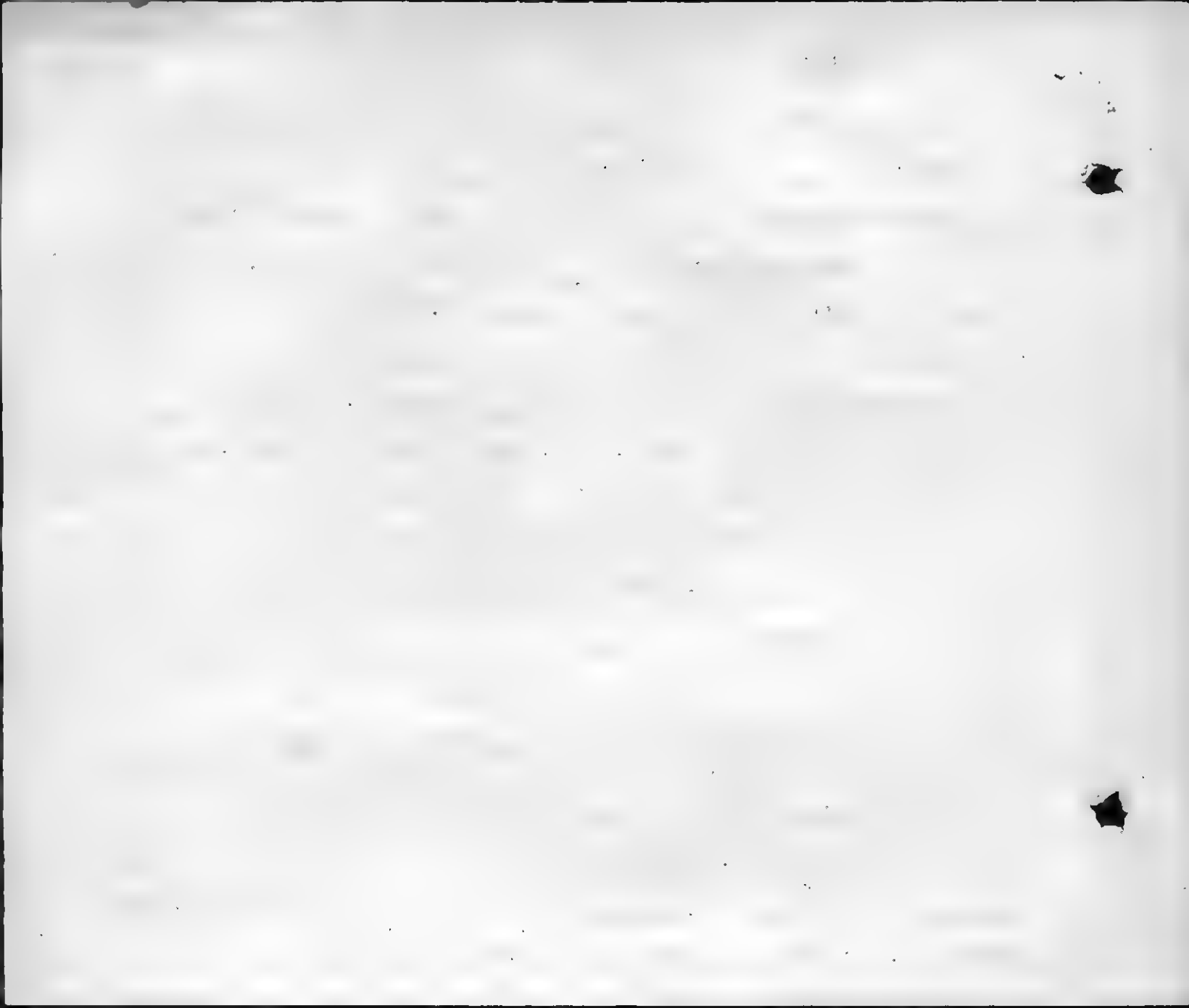
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02055

CERTIFICATE OF DEATH

02038

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b 34 days		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 5733 Crawford Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harriett Mackall		First		Middle		Last Griffith		4. DATE OF DEATH Feb. 8 19 62		Month		Day		Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 11, 1870		9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME David Griffith		14. MOTHER'S MAIDEN NAME Annie S. Taylor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT W. Basil Mobley, Derwood, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) bronchopneumonia DUE TO congestive heart failure DUE TO arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) uremia		INTERVAL BETWEEN ONSET AND DEATH 4 days 33 days years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) NONE		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 30, 1961 , to Feb. 8, 1962 , that (I) (was) last saw the deceased alive on Feb. 8, 1962 , and that death occurred at 9 A.M. , from the causes and on the date stated above																	
22a. SIGNATURE Stephen C. Cromwell		22b. DATE SIGNED 2-8-62		22c. PHYSICIAN'S NAME (Type) Stephen C. Cromwell		22d. ADDRESS 615 W. Montgomery Ave Rockville, Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. (City or town) (County) (State)		22g. (City or town) (County) (State)		22h. (City or town) (County) (State)			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2/10/62		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR Feb 13 '62		24b. REGISTRAR'S SIGNATURE W. Basil Mobley		24c. (City or town) (County) (State)			



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MARYLAND STATE DEPARTMENT OF HEALTH

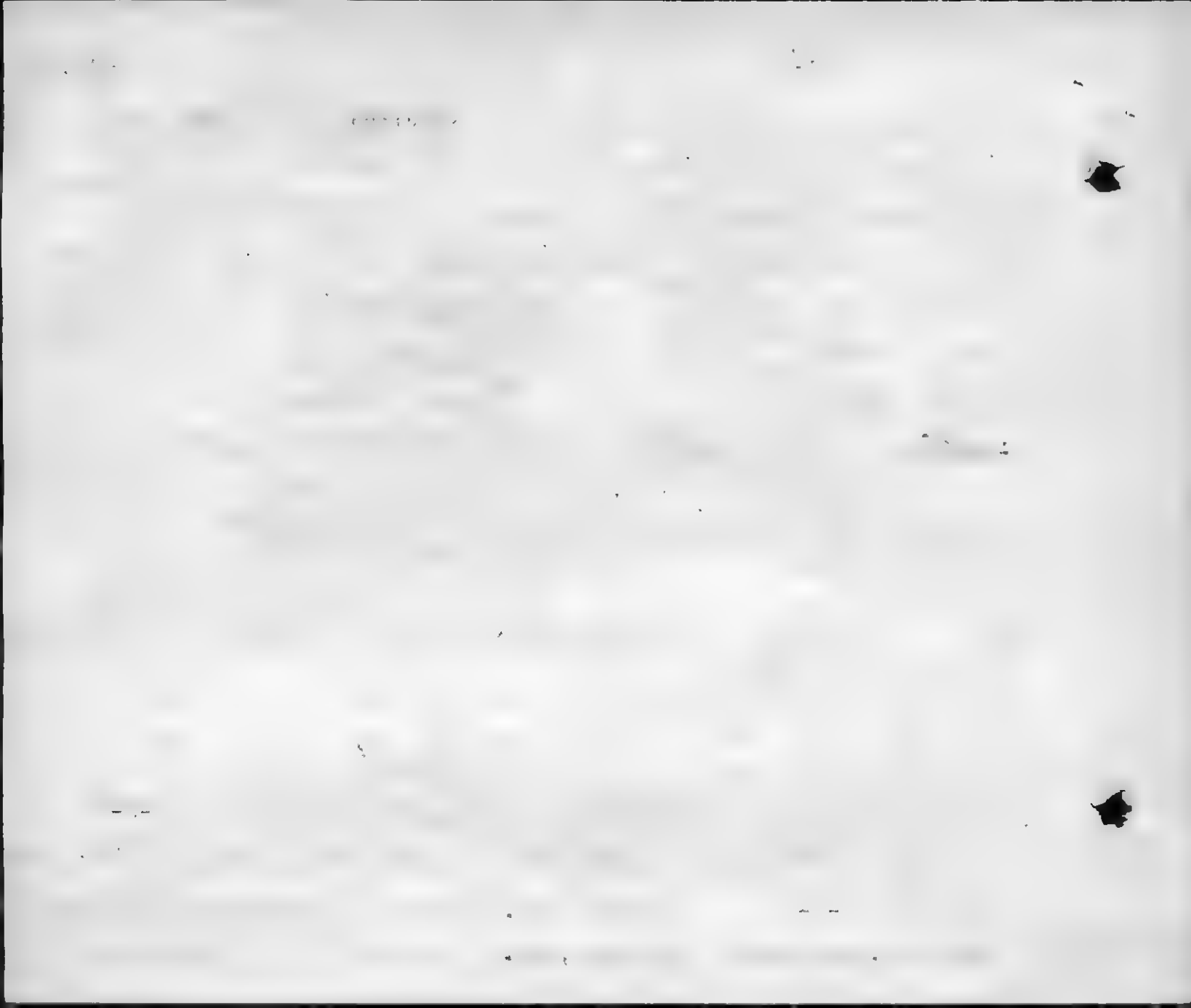
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02057

02039

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 month 7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmor Sanitarium, 5721 Grosvenor Lane</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5000 Westpath Terrace</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Frederick HALL</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 22, 1874</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GRAIN DEALER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Elihu HALL</u>				14. MOTHER'S MAIDEN NAME <u>JANE Culbert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>LEONARD HALL (Son) - 5000 Westpath Terrace, WASHINGTON, D.C.</u>				18. CAUSE OF DEATH (Enter only one cause part (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Lobar, Rt lower lobe</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebrovascular accident</u> (c) <u>3 wks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia; Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 7, 1961</u> to <u>2-2-1962</u> that (I) (we) last saw the deceased alive on <u>2-1-1962</u> and that death occurred <u>6:59</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Stephen W. Deiter</u>				22b. DATE <u>2-2-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN W. DEITER, M.D.</u>				22d. ADDRESS <u>6719 WILSON LA, BETHESDA, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-5-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Mem. Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				25a. REC'D BY REGISTRAR <u>FEB 7 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

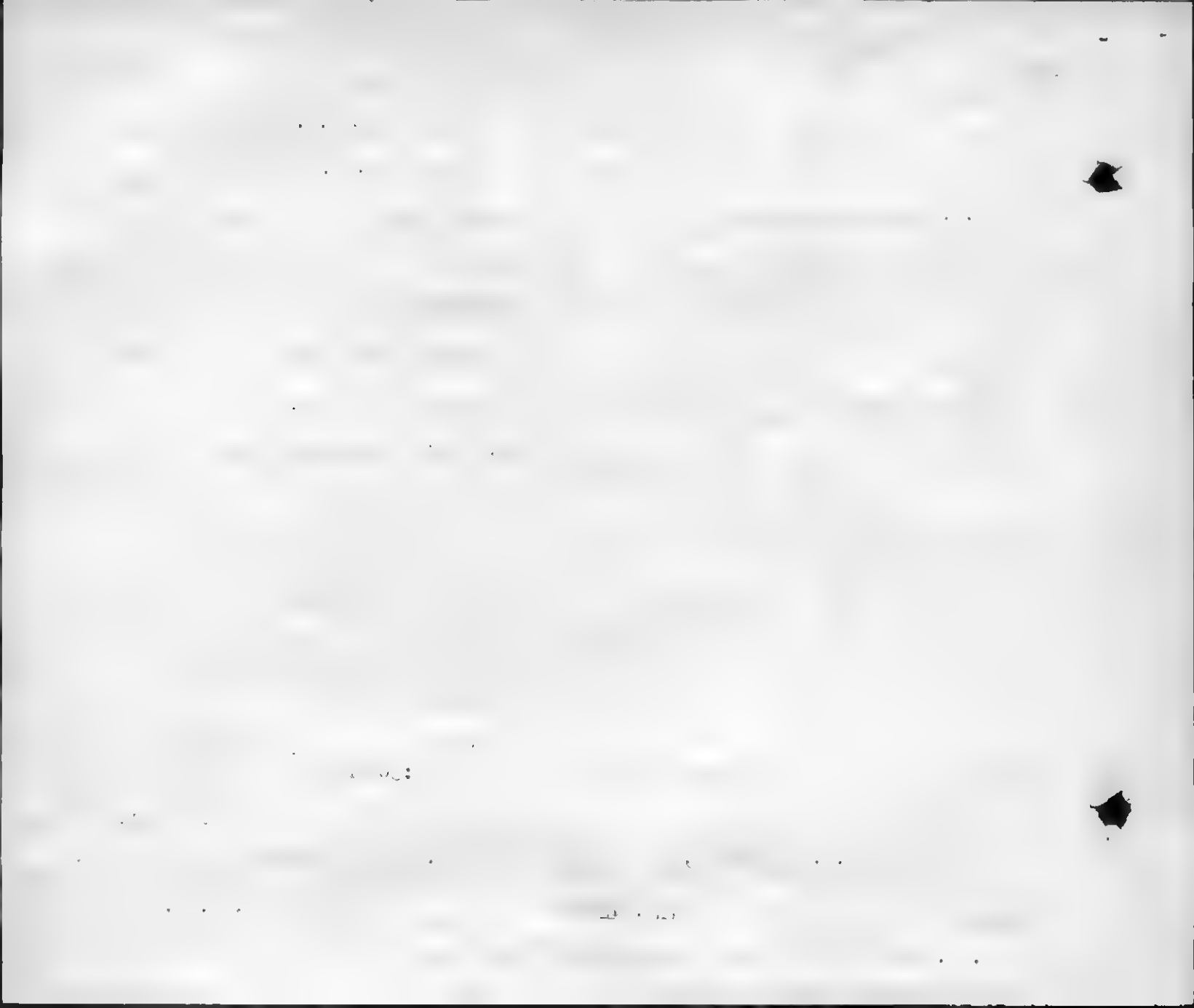
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02058

02040

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN 1b 1 hour d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Washington D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 707 G.-St. SE	
3. NAME OF DECEASED (Type or print) KIMBERLY LEE HAM		4. DATE OF DEATH Month February Day 18 Year 1962	
5. SEX Female		6. COLOR OR RACE Cauc	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 February 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Ralph Ham		14. MOTHER'S MAIDEN NAME Virginia Lee Zacny	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Father: Charles Ralph HAM Same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Neonatal Death DUE TO 773.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a); 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that 10 (this hospital) attended the deceased from 18 February, 1962 , to 18 February, 1962 , that 1 (we) last saw the deceased alive on 18 February, 1962 , and that death occurred at 6:30 AM the causes and on the date stated above. 22a. SIGNATURE F.A. SCHULANER, LT MC USN M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE 18 February 1962 22c. PHYSICIAN'S NAME (Type) F.A. SCHULANER, LT MC USN 22d. ADDRESS U.S. Naval Hospital, Bethesda, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 20 FEB 1962 23c. NAME OF CEMETERY OR CREMATORY MOUNT. OLIVER 23d. LOCATION (City, town or county) (State) WASHINGTON, D. C. 24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS ADDRESS 517 11th ST SE WASHINGTON DC 25a. REC'D BY REGISTRAR FEB 21 1962 25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			



may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02041

02059

1. PLACE OF DEATH a. COUNTY Montgomery. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Altavista Nursing Home				e. STREET ADDRESS 5516 Charlotte St.			
3. NAME OF DECEASED (Type or print) First Emma Middle Gibbon Last HAMMER				4. DATE OF DEATH Month Feb Day 25 Year 1962			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1886	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Phila. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles S. Gibbon				14. MOTHER'S MAIDEN NAME Anna Ottersen.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT John L. HAMMER Jr			Address 101 L. Bruce Rd. N.J.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 42 0-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Occlusion DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 26 hrs 26 hrs 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous MASTECTOMY - Bilateral - Malignant - 6 yrs.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from May, 1960 to Feb 25, 1962 , that (I) (we) last saw the deceased alive on Feb 24, 1962 , and that death occurred at 12:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE James E. Nolan		M.D. <input checked="" type="checkbox"/> ATTENDING PHYSICIAN	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22b. DATE SIGNED 2-25-62		
22c. PHYSICIAN'S NAME (Type) JAMES E. NOLAN		22d. ADDRESS 5401 Western Ave NW Wash D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit	23b. DATE THEREOF 2-25-62	23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery	23d. LOCATION (City, town, or county) (State) Ht. Airy, Penna.				
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE 2/25/62	25b. REGISTRAR'S SIGNATURE Wm. L. Puma		

M

90

I

MEDICAL CERTIFICATION

Burial-transit 2-25-62

Ivy Hill Cemetery

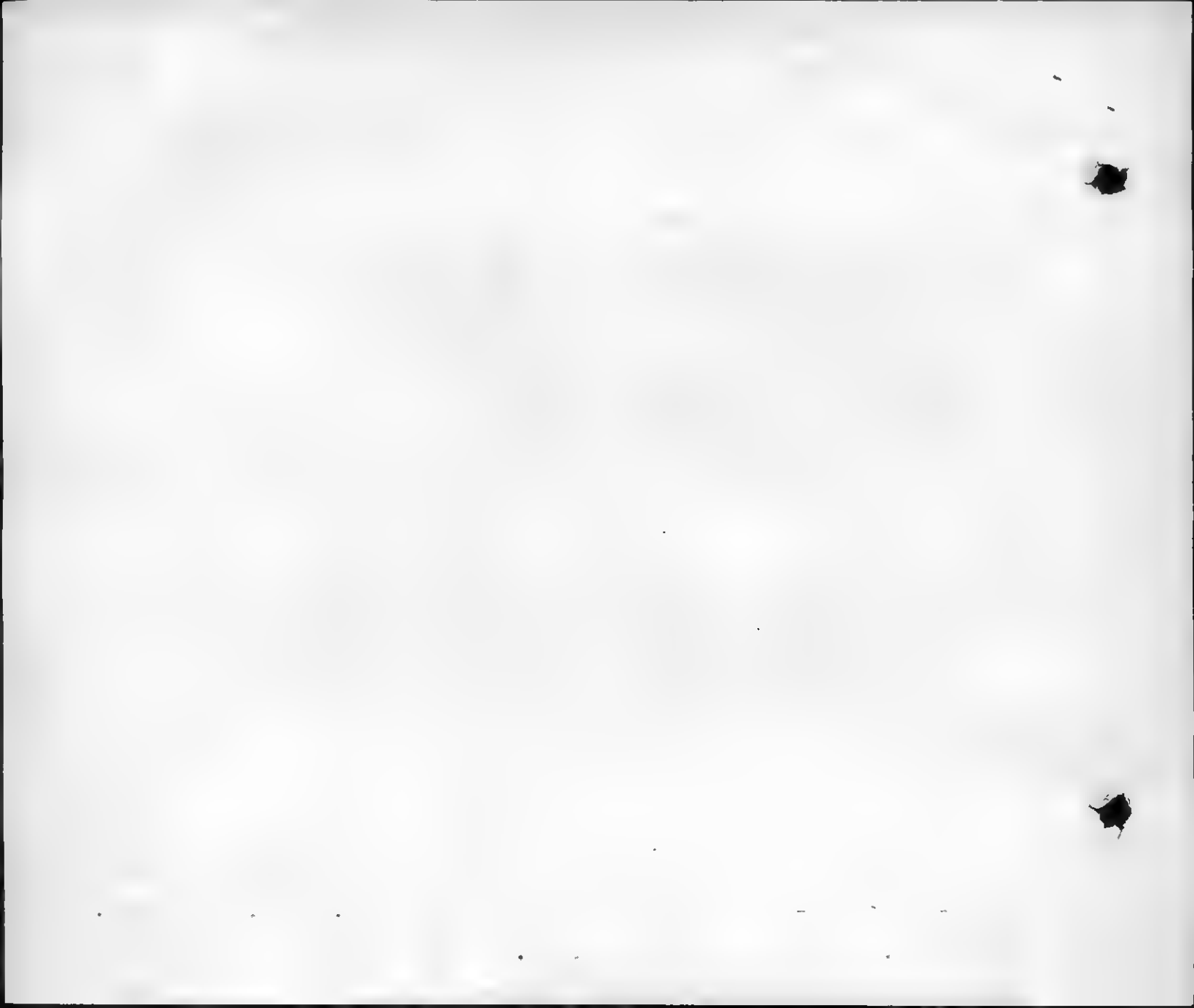
Ht. Airy, Penna.

ROBERT A. PUMPHREY

Bethesda, Md.

DATE 2/25/62

Wm. L. Puma



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

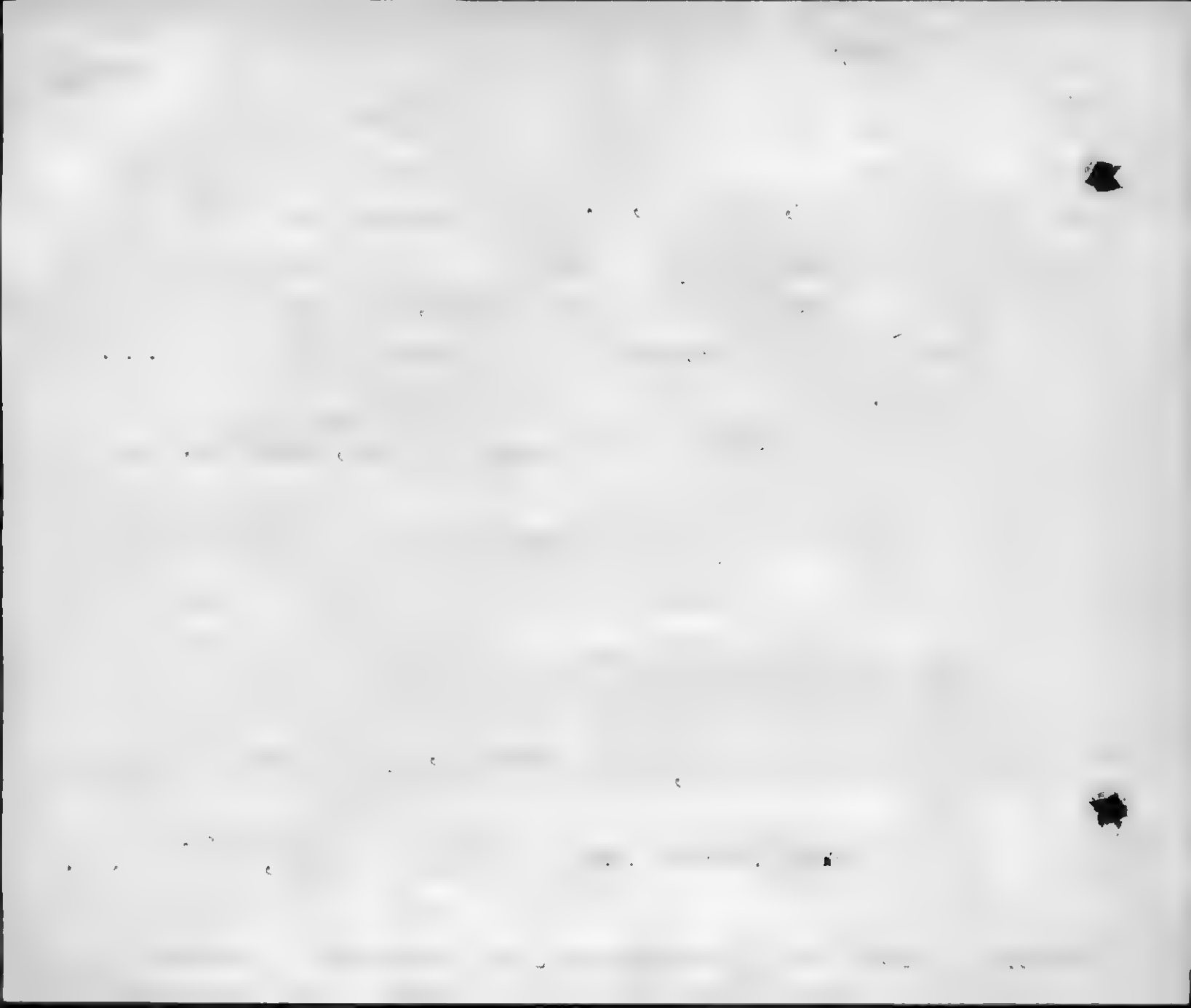
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02060

02042

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>46 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Bethesda</u> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>6408 Red Wing Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF (Type or print) <u>Wendell Deady Hance</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>November 4, 1913</u>		9. AGE (In years) IF UNDER 1 YEAR <u>48</u> yrs. IF UNDER 24 HRS. <u>48</u> Months Days Hours Mins.	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Economist</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u> 11. BIRTH-PLACE (County & State, or foreign country) <u>Illinois</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Oscar M. Hance</u>				14. MOTHER'S MAIDEN NAME <u>Anna Deady</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> 16. SOCIAL SECURITY NO. (If yes, give war or date of service) <u>WW II Unascertainable</u> 17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda 14, Maryland</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypernephroma</u> DUE TO (b) <u>Leurocristine toxicity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Fever of unknown origin</u> <u>Malnutrition secondary to cancer</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>2 weeks</u> <u>2 weeks</u> <u>2 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <u>He</u> (this hospital) attended the deceased from <u>January 3, 1962</u> to <u>February 18, 1962</u> , that <u>he</u> (we) last saw the deceased alive on <u>February 18, 1962</u> , and that death occurred at <u>10:00</u> p.m. from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard S. Rivlin, M.D.</u>				22b. DATE SIGNED <u>February 19, 1962</u>				22c. PHYSICIAN'S NAME (Type or print) <u>Richard S. Rivlin, M.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				23b. DATE THEREOF <u>2-20-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Leea Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u>				ADDRESS <u>300 4th St. N.E. Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>Feb 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hance</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

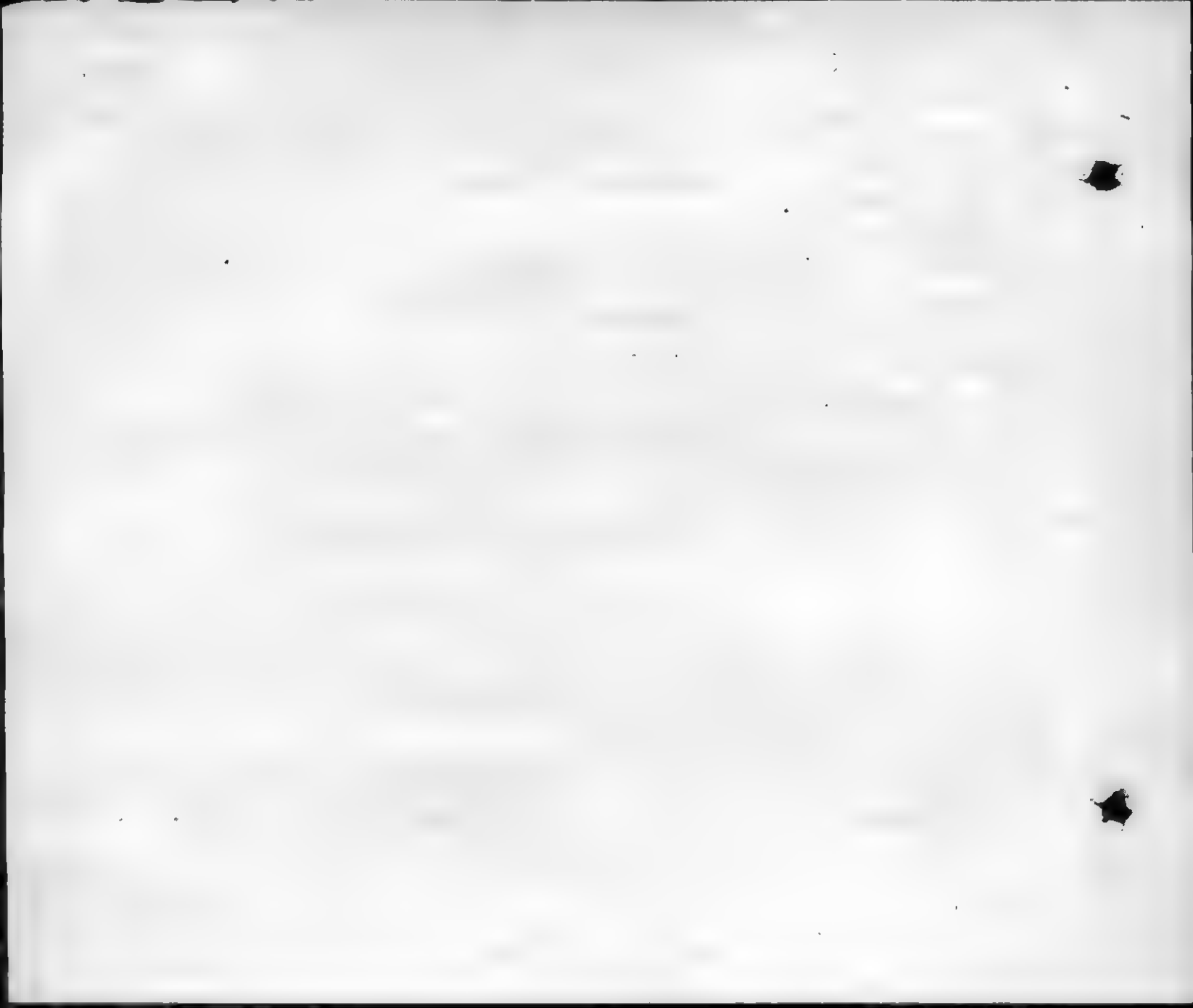
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02061

02043

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5004 Keokuk St.		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 5004 Keokuk Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATE Middle C Last HANSHEW		4. DATE OF DEATH Month Feb. Day 25 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/23/1874	
9. AGE (In years last birthday) 87 yrs. Months 2 Days 2		10. IF UNDER 1 YEAR Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles J. Brewer		14. MOTHER'S MAIDEN NAME Annie S. Divine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 577-10-7819D	
17. INFORMANT Rose L. Hanshaw-daughter-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sanguine of right foot Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of tibial artery (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to February 25, 1962 ; that (I) (we) last saw the deceased alive on February 25, 1962 , and that death occurred at 12:00 PM from the causes and on the date stated above.			
22a. SIGNATURE Alfred Baer, M.D. M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> Feb. 25, 1962	
22c. PHYSICIAN'S NAME (Type) ALFRED BAER, M.D.		22d. ADDRESS 730 24th St NW. Washington 7 D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/62	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS	
25a. REC'D BY REGISTRAR MAR 1 1962		25b. REGISTRAR'S SIGNATURE Wm. S. Evans	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02062

02044

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>54 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u> d. STREET ADDRESS <u>ROUTE #3</u>	
3. NAME OF DECEASED (Type or print) <u>MINNA S. HANSON</u>		4. DATE OF DEATH Month <u>2</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/23/88</u> 9. AGE (In years last birthday) <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON D.C. U.S.</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>EMIL GEORGE SCHAFER</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>UNK.</u>		17. INFORMANT <u>SON ROBERT</u> 18. MOTHER'S MAIDEN NAME <u>MARY C. WALTER</u> Address <u>6008 KIABY RD BETH</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>RENAL FAILURE</u> DUE TO (c) <u>CARCINOMA UTERUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u>FRACTURE Left Hip</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>0</u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 17, 1961</u> , to <u>FEB 23 1962</u> , that (I) (we) last saw the deceased alive on <u>FEB 22, 1962</u> , and that death occurred at <u>5AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Brewer</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>ROBERT GEORGE BREWER</u>		22b. DATE SIGNED <u>2/23/62</u> 22d. ADDRESS <u>8218 WISCONSIN AVE BETHMD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>2/23/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>1331 E. Lincoln Montgomery Ave.</u> 23d. LOCATION (City, town or country) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>		25. REC'D BY REGISTRAR <u>C. L. S. Kinn</u> 25b. REGISTRAR'S SIGNATURE DATE <u>FEB 26 '62</u>	



1
FOR STATE
HEALTH DEPT.

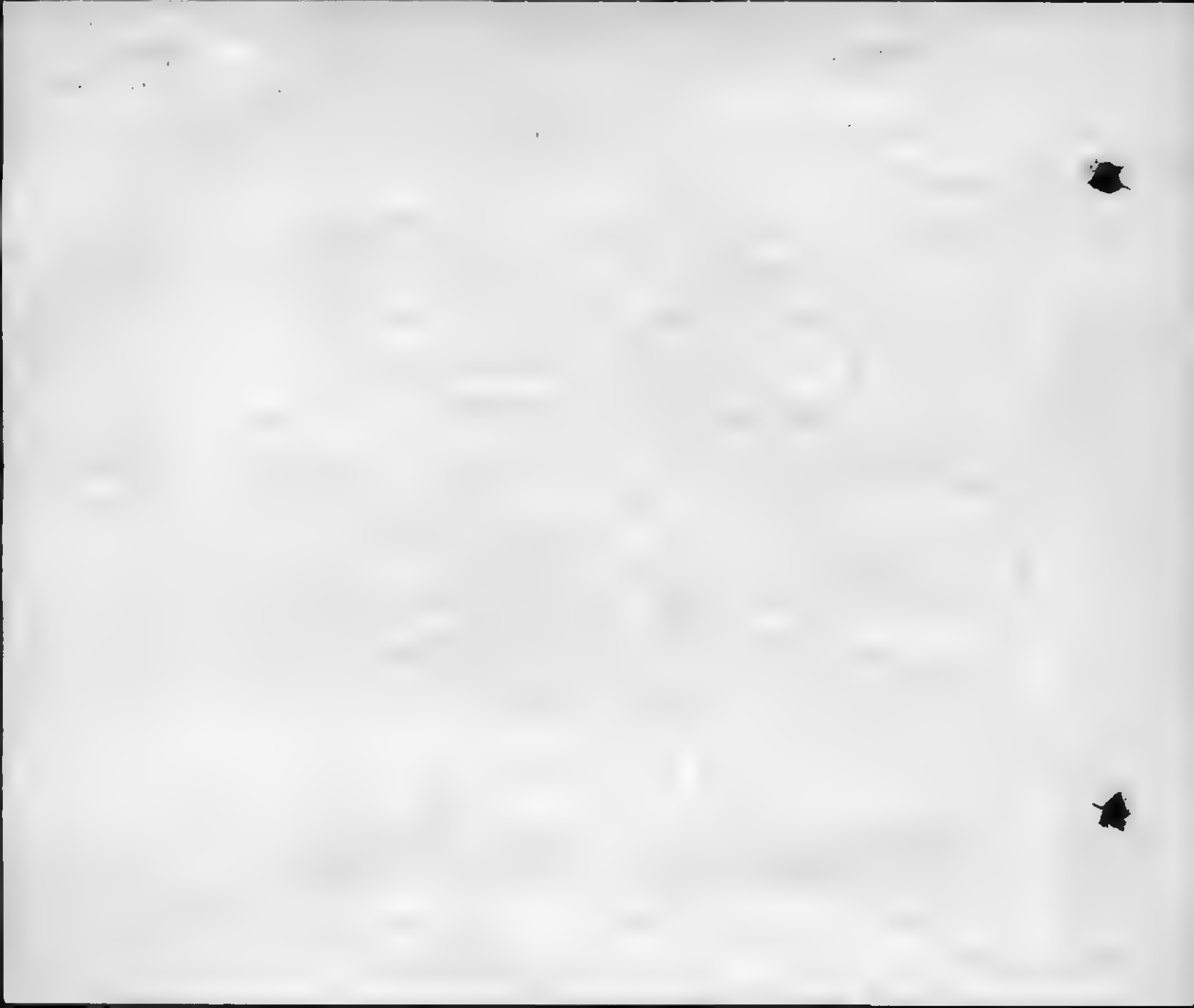
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02045

1. PLACE OF DEATH
a. COUNTY *Montgomery* b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) *Faithersburg* c. LENGTH OF STAY IN 1b *MARYLAND*
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) *901 Zetta Ave*
2. USUAL RESIDENCE (Where deceased lived, if not last one; Residence before admission)
a. STATE *md* b. COUNTY *Montg* c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) *Faithersburg*
d. STREET ADDRESS *901 Zetta Ave* e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) *Robert Neal Hardy* 4. DATE OF DEATH *Feb 12 1962*
5. SEX *male* 6. COLOR OR RACE *white* 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH *2-2-62*
9. AGE (In years last birthday) *28* 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *none* 11. BIRTHPLACE (State or foreign country) *md*
12. CITIZEN OF WHAT COUNTRY? *md*
13. FATHER'S NAME *Donald Hardy* 14. MOTHER'S MAIDEN NAME *Yvonne Welling*
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) *no* 16. SOCIAL SECURITY NO. *Yvonne Hardy (mother)* 17. INFORMANT *Yvonne Hardy (mother)*
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Asphyxia*
763-0 DUE TO *upper Respiratory Infection*
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) *Asphyxia*
DUE TO (c) *upper Respiratory Infection*
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) *Asphyxia*
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
ACTUAL SIGNATURE *Frank J. Bruchant* M.D. DATE SIGNED *2-12-62*
EXAMINER'S NAME (Type) *FRANK J. Bruchant* Address (Street, city, town, or county) *2-12-62*
22a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 22b. DATE THEREOF *2-14-62* 22c. NAME OF CEMETERY OR CREMATORY *Arlington National* 22d. LOCATION (City, town, or country) (State) *Arlington Va*
23. FUNERAL DIRECTOR *Ernest B. Gartner, Faithersburg, Md* ADDRESS *2-14-62* 24a. REC'D BY REGISTRAR *Ernest B. Gartner* 24b. REGISTRAR'S SIGNATURE *Ernest B. Gartner*

VS. A15ME
SM 9/60

2073334155

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be turned to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

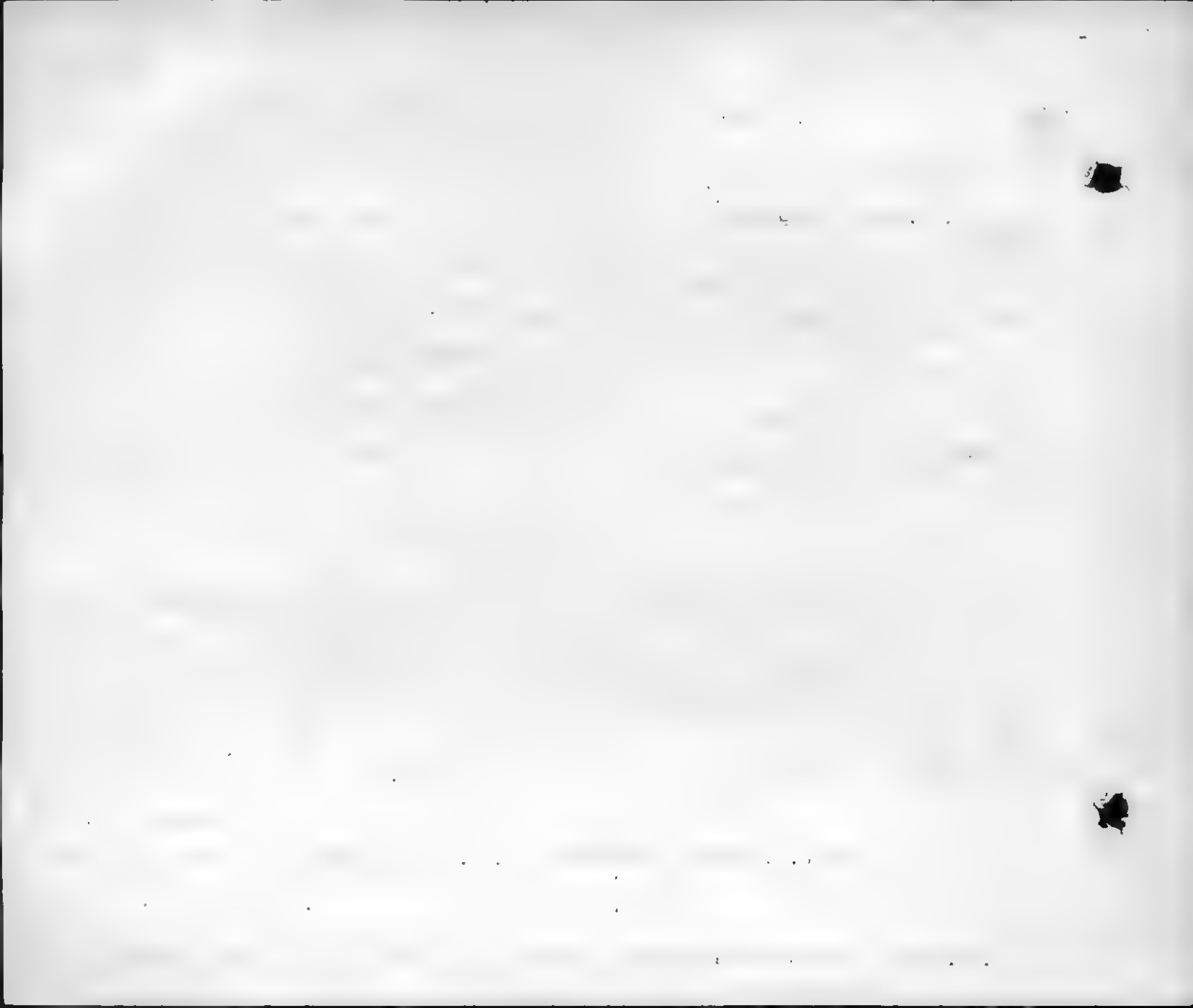
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02064

02046

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Westminster</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		d. STREET ADDRESS <u>152 West Main Street</u>	
3. NAME OF DECEASED (Type or print) <u>Richard Cresson Harlow</u>		4. DATE OF DEATH <u>February 19, 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>October, 19, 1889</u>		9. AGE (in years last birthday) <u>72 yrs.</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIDOWED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Harlow</u>		14. MOTHER'S MAIDEN NAME <u>Eugenia Pritchett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>Jan. 13, 1962</u> to <u>Feb. 19, 1962</u> that <u>he</u> (we) last saw the deceased alive on <u>Feb. 19, 1962</u> and that death occurred at <u>1:20 AM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>James J. Cavanagh</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>February 19, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES J. CAVANAGH LT MC USN</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-22-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Pine Groove Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>S. Sterling, Pa.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers</u> - Per H. J. Schmitt J. E. MYERS Funeral Home, Westminster, Md. 25a. REC'D BY REGISTRAR DATE <u>FEB 21 '62</u> 25b. REGISTRAR'S SIGNATURE <u>James J. Cavanagh</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

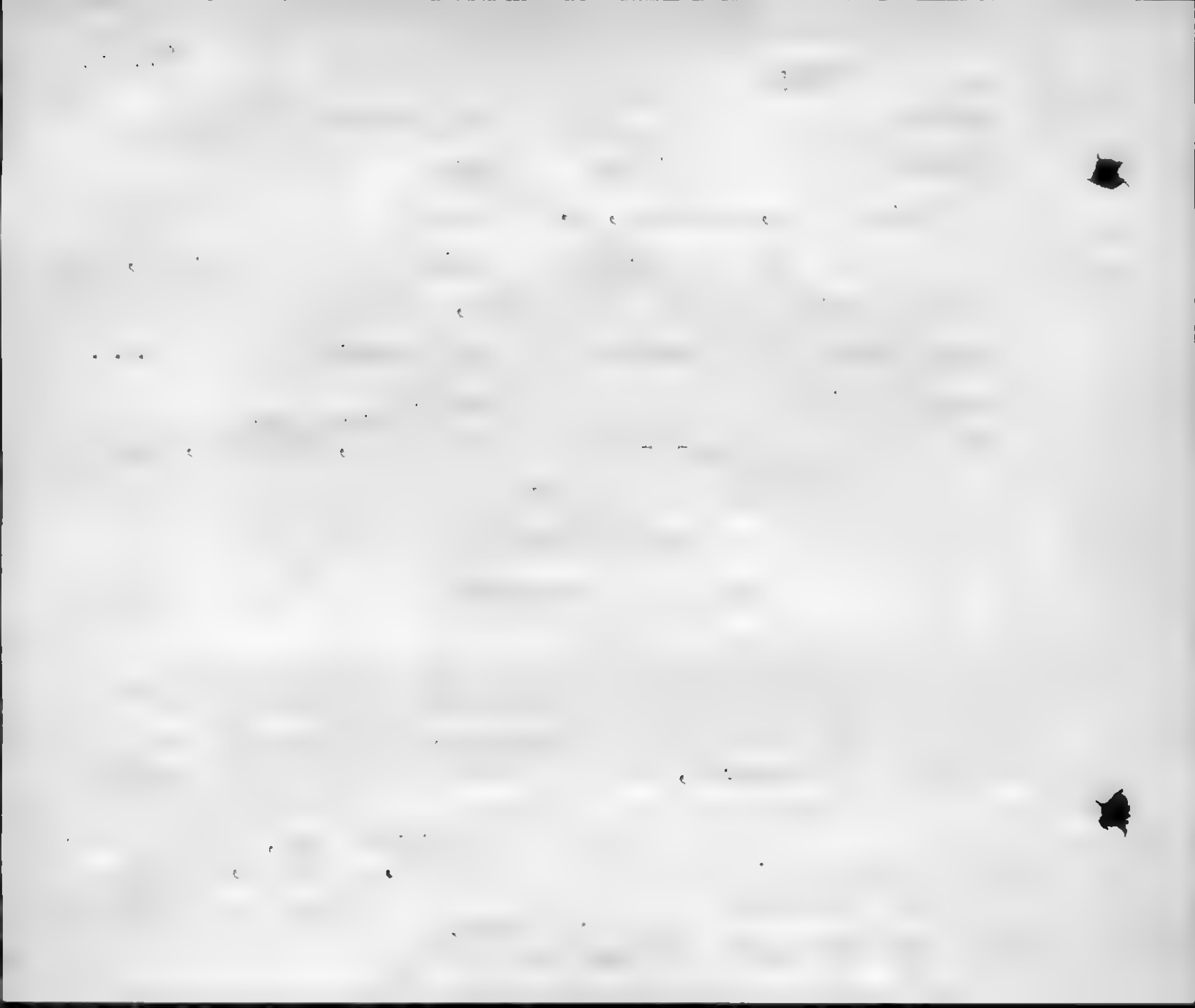
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02047

02065

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE North Carolina b. COUNTY Hudson c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Box 475 d. STREET ADDRESS Box 475	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month Day Year February 8, 19 62	
3. NAME OF DECEASED (Type or print) Lula Macbelle Harris		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH June 3, 1908 9. AGE (In years, last birthday) 53 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile weaver 11. BIRTHPLACE (County & State, or foreign country) North Carolina 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustus Benfield		14. MOTHER'S MAIDEN NAME Kate Mundy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 241-05-1866	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Acute Myelogenous Leukemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 month		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 1, 1962 to February 8, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 8, 1962 , and that death occurred at 4:15 AM , from the causes and on the date stated above.			
22a. SIGNATURE Robert H. Levin		22b. DATE SIGNED February 8, 1962	
22c. PHYSICIAN'S NAME (Type) Robert H. Levin		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL BURIAL FEB. 11/62		23b. DATE THEREOF FEB. 11/62	
23c. NAME OF CEMETERY OR CREMATORY LENOR, NORTH CARO.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong		25. REC'D BY REGISTRAR 13 '62	
25b. REGISTRAR'S SIGNATURE 13 '62		25c. REGISTRAR'S SIGNATURE 13 '62	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02066

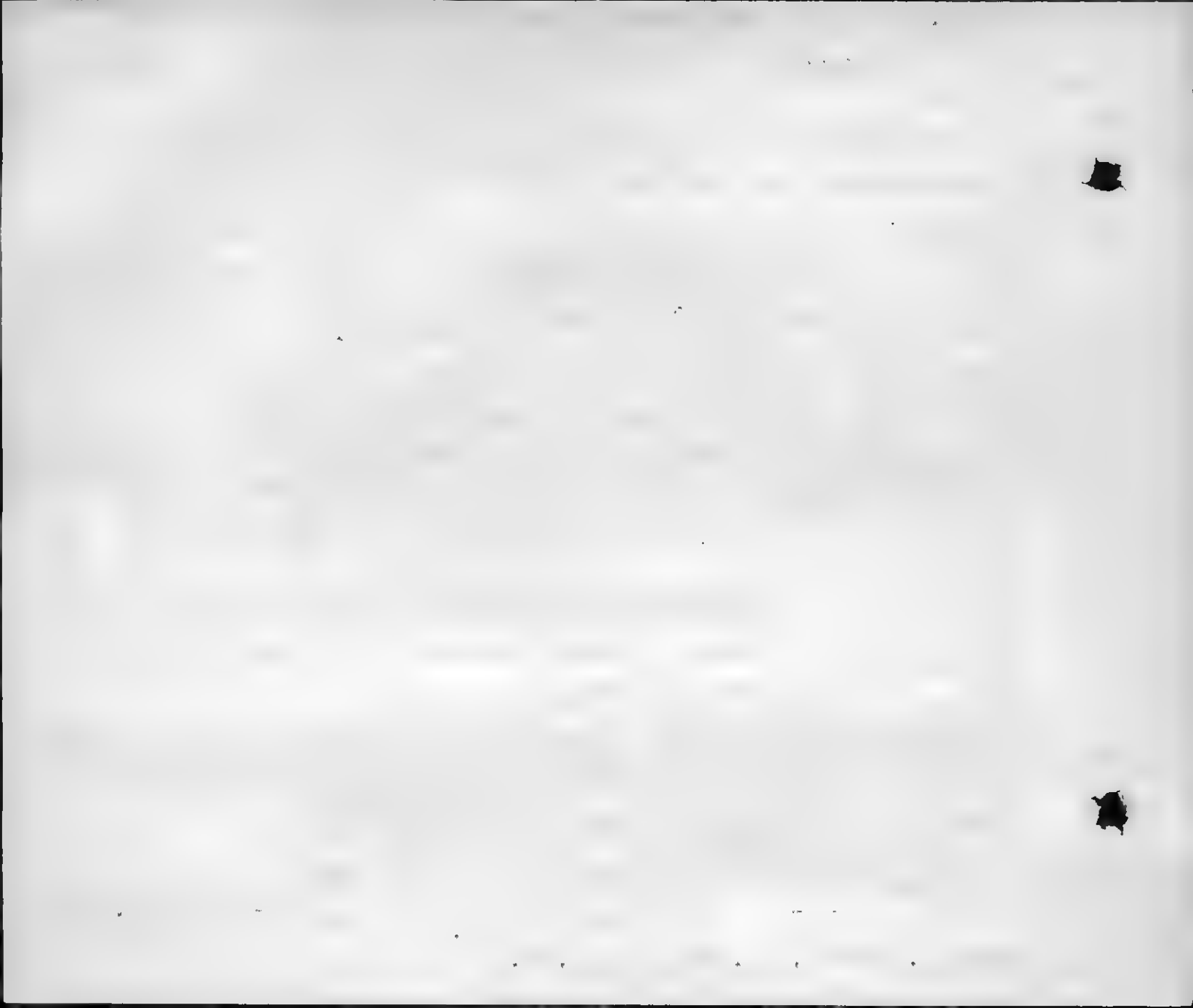
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02048

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Udley</u> c. LENGTH OF STAY in b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. General Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if last habitation; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>512 Domes Cove</u>	
3. NAME OF DECEASED (Type or print) <u>Violet Elizabeth Hawkins</u> First Middle Last		4. DATE OF DEATH <u>Feb 17 1962</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4-7-1913</u> 9. AGE (In years last birthday) <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical Engineer</u> 11. BIRTHPLACE (State or foreign country) <u>Spotsylvania Co. Va</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Huston Acors</u>		14. MOTHER'S MAIDEN NAME <u>Brooks Nolie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Florence Heplin</u> Address <u>801 N. Boulevard St Richmond VA</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE <u>Contusion med. oblongata - Subarachnoid hemorrhage</u> DUE TO <u>Fracture 3rd & 4th C. V. - hemoperitoneum hem. 250 cc</u> DUE TO <u>Multiple laceration of spleen & liver - crushed chest, rt</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident - driver</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:40 p.m. 2-17 1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>md R-29</u> 20f. (City or town) <u>Simpsonville Howard md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-18-62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or country) <u>Arlington-Arlington Co. Virginia</u>	
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> Address <u>34 Georgia Ave.</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 21 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	



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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Shady Grove</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Shady Grove</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Shady Grove Rd.</u>									
3. NAME OF DECEASED (Type or print) <u>Herbert H. Heflin</u>		DATE OF DEATH Month <u>Feb</u> Day <u>18</u> Year <u>1962</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>									
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4/10/1880</u>		9. AGE (In years last birthday) <u>81</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>John Hopkins</u>									
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>W. C. Heflin</u>		14. MOTHER'S MAIDEN NAME <u>Carmie Hayer</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-14-6725</u>									
17. INFORMATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>essential hypertension</u> (a), stating the underlying cause last. (c) <u>arteriosclerotic cardiovascular disease</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>									
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <table border="1"> <tr> <td>While at work</td> <td>Not While at work</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		While at work	Not While at work	<input type="checkbox"/>	<input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>					
While at work	Not While at work										
<input type="checkbox"/>	<input type="checkbox"/>										
21. I certify that (I) (This hospital) attended the deceased from <u>October 1954</u> to <u>Feb. 18, 1962</u> that (I) (We) last saw the deceased alive on <u>Feb 18, 1962</u> and that death occurred at <u>4:30 p.m.</u> from the causes and on the date stated above.		22b. DATE SIGNED <u>2-18-62</u>									
22a. SIGNATURE <u>Stephen C. Cromwell</u> M.D. <table border="1"> <tr> <td>ATTENDING PHYS.</td> <td>MED. DIRECTOR</td> <td>STAFF PHYS.</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22d. ADDRESS <u>Rockville, Md</u>			
ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.									
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell, M.D.</u>		23d. LOCATION (City, town or county) <u>Rockville, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/21/62</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		23d. LOCATION (City, town or county) <u>Beallsville, Maryland</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Heeler</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 21 '62</u>									
25b. REGISTRAR'S SIGNATURE <u>C. Stuart L. Kraus</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02068

02050

1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 53 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Tennessee b. COUNTY Greenville c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenville d. STREET ADDRESS 615 Franklin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Sue Hite		4. DATE OF DEATH Month Day Year February 19 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 12, 1928	
9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS., last birthday) 34 yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (Country & State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Daniel Boles	
14. MOTHER'S MAIDEN NAME Anna Flora Kesterson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) NO	
16. SOCIAL SECURITY NO. 410-34-4415		17. INFORMANT The Medical Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Breast with Metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 13 months INTERVAL BETWEEN ONSET AND DEATH 2 weeks		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 28, 1961, to February 19, 1962, that (if (we) last saw the deceased alive on February 19, 1962, and that death occurred at 8:25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Michael Field		22b. DATE SIGNED February 19, 1962	
22c. PHYSICIAN'S NAME (Type, Michael Field, M.D.)		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 2/19/62	
23c. NAME OF CEMETERY OR CREMATORY --		23d. LOCATION (City, town or county) (State) Greenville, Tennessee	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.-2901 14th St., N.W. Wash.		25a. REC'D BY REGISTRAR DATE FEB 21 '62	
25b. REGISTRAR'S SIGNATURE Curtis S. Pearson			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02069

02051

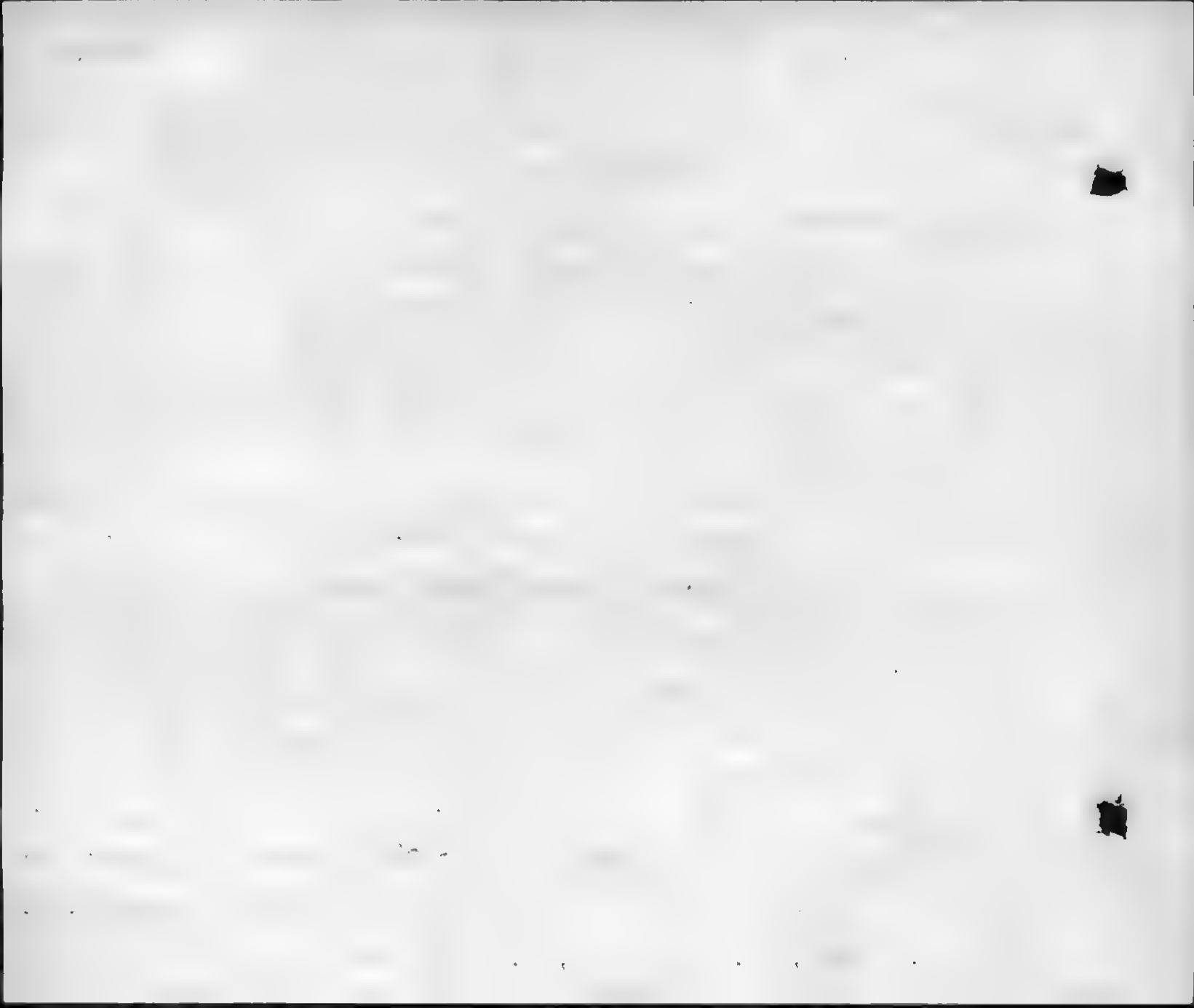
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i> c. LENGTH OF STAY IN 1b <i>2 years</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>6900 Strathmore Street</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>41 Chevy Chase 15 Md</i> d. STREET ADDRESS <i>6900 Strathmore St.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>Agnes Ferguson Hopkins</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>3</i> Year <i>1962</i>		5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 29 1905</i>		9. AGE (in years last birthday) <i>56</i> yrs. IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> IF UNDER 24 HRS.: Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Administrative</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Glasgow Scotland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Robert F. Ferguson</i>						14. MOTHER'S MAIDEN NAME <i>Agnes J. Arthur</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NE</i> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <i>579-46-0651</i>				17. INFORMANT Address <i>Mrs. Agnes Ferguson 6900 Strathmore St</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i> DUE TO <i>carcinoma of right breast</i> Conditions, if any, which gave rise to immediate cause (b) <i>5 years</i> (c) <i>170X</i> DUE TO <i>carcinoma of right breast</i> (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Emphysema</i>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>											
20c. TIME OF INJURY Month, Day, Year Hour <i>None</i> a.m. <i>None</i> p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <i>9/28</i> 1961 , to <i>2/3</i> 1962 , that (I) (we) last saw the deceased alive on <i>2/3</i> 1962 , and that death occurred <i>12:15</i> M. from the causes and on the date stated above.															
22a. SIGNATURE <i>John B. Umhau</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2/5/62</i>		22c. PHYSICIAN'S NAME (Type) <i>John B. Umhau</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>				23b. DATE THEREOF <i>2/6/62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>				23d. LOCATION (City, town or county) <i>Suitland, Md.</i> (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Company</i>						ADDRESS <i>2901 14th St. N.W.</i>		25a. REC'D BY REGISTRAR <i>DATE 2/5/62</i>		25b. REGISTRAR'S SIGNATURE <i>Carroll S. Hines</i>					



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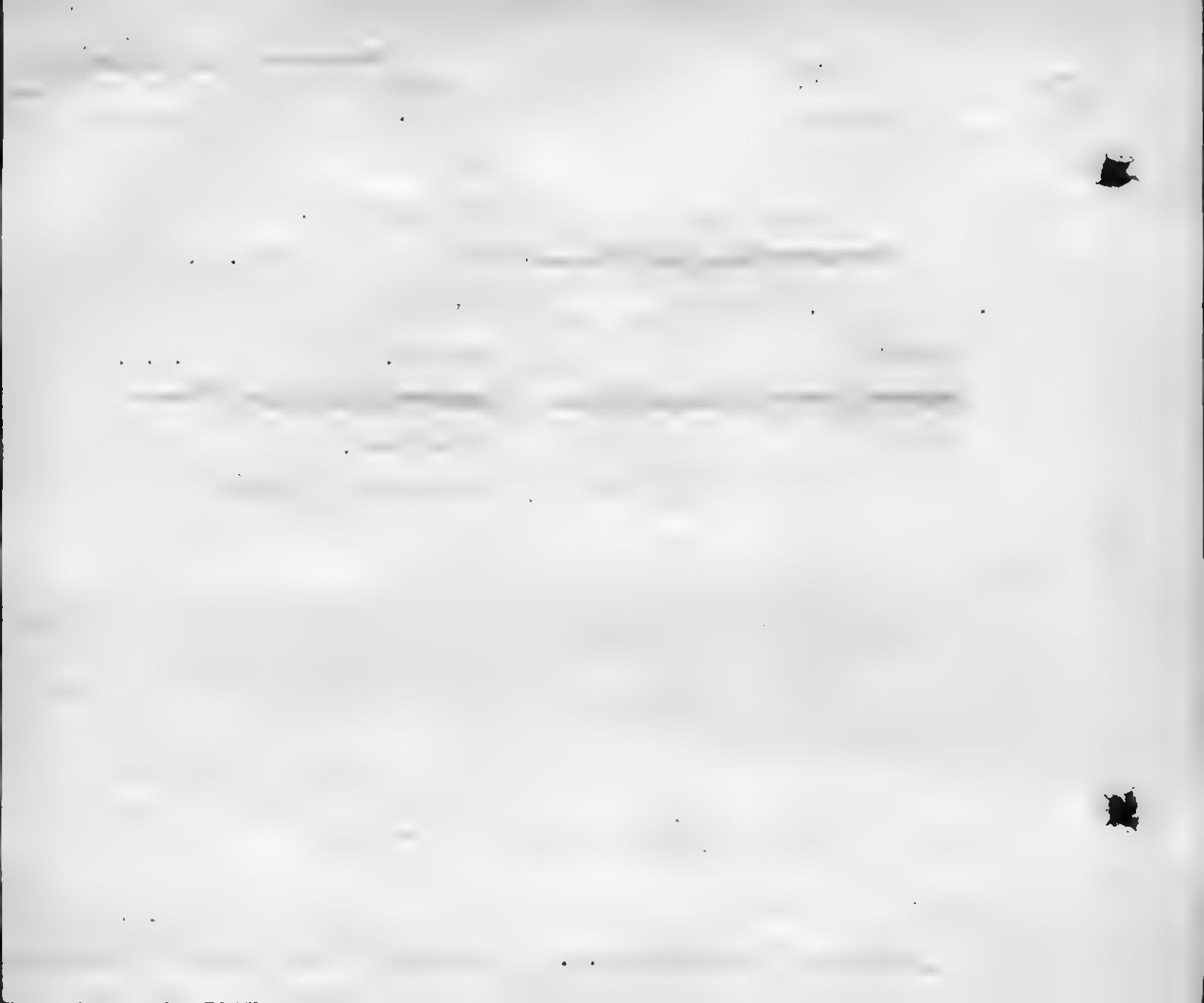
VR A15 (4)
15M 9/60

<div style="display: flex; justify-content: space-between;"> <div> <p>02070</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>02052</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 hr. 40 min. Silver Spring</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>						2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8310-16th St. Silver Spring</u> d. STREET ADDRESS <u>8310-16th St.</u> e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Edythe May Hope</u> 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>3/21/91</u> 8. WIDOWED <input type="checkbox"/> D. DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF 19 62 HRS.						4. DATE OF DEATH Month <u>Feb</u> Day <u>4</u> Year <u>1962</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 13. FATHER'S NAME <u>(unknown)</u> 14. MOTHER'S MAIDEN NAME <u>Hess</u> <u>FLORENCE C. FITCH</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>LLOYD F. Hoppe</u> Address <u>20.</u>					
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Anteriosclerosis, generalised</u> (c) <u>Hypertension, mod. severe</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____											
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>Feb 4</u> 1962 that (I) (we) last saw the deceased alive on <u>Feb 4</u> 1962 and that death occurred at <u>9:30</u> P.M. from the causes and on the date stated above. 22a. SIGNATURE <u>Cluett Clapp</u> 22b. DATE SIGNED <u>2.5.62</u> 22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp MD</u> 22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase 15 Md.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-7-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> 23d. LOCATION (City, town or county) <u>Suitland Prince Georges Co. Md.</u> (State) _____											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>1434 Georgia Ave</u> REC'D BY REGISTRAR <u>Feb 7 '62</u> 25b. REGISTRAR'S SIGNATURE <u>William J. Ziska</u>											



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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington Tokema Park d. STREET ADDRESS 7003 Westmoreland Ave. 10237/24161/PL.		3. NAME OF DECEASED (Type or print) Caroline Homozelle Mason Hornor First Middle Last 4. DATE OF DEATH Feb. 9, 1962 19 Month Day Year		5. SEX F. 6. COLOR OR RACE W. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1871 9. AGE (In years last birthday) 90 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY West Va. 11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? No (Yes, No or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Struthe Carr Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of urinary Bladder 191.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) 191.0 (c), stating the underlying cause last. DUE TO (c) 191.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Serious Arteriosclerosis													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from... 1950... to 9 Feb 1962 that (I) (we) last saw the deceased alive on... 3 Feb 1962 and that death occurred at 2:30 P.M. from the causes and on the date stated above.													
22a. SIGNATURE M. B. QUEEN		22b. DATE SIGNED 9 Feb 1962		22c. PHYSICIAN'S NAME (Type) M. B. QUEEN		22d. ADDRESS 7112 Willow Ave Takoma Park, Md		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-9-62		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium		23d. LOCATION (City, town or county) Washington D.C.		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE Arthur S. Frank			
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home Wash D.C.		24a. ADDRESS		24b. DATE FEB 13 '62		24c. DATE		24d. DATE		24e. DATE			



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VR A15 (4)
15M 7161

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

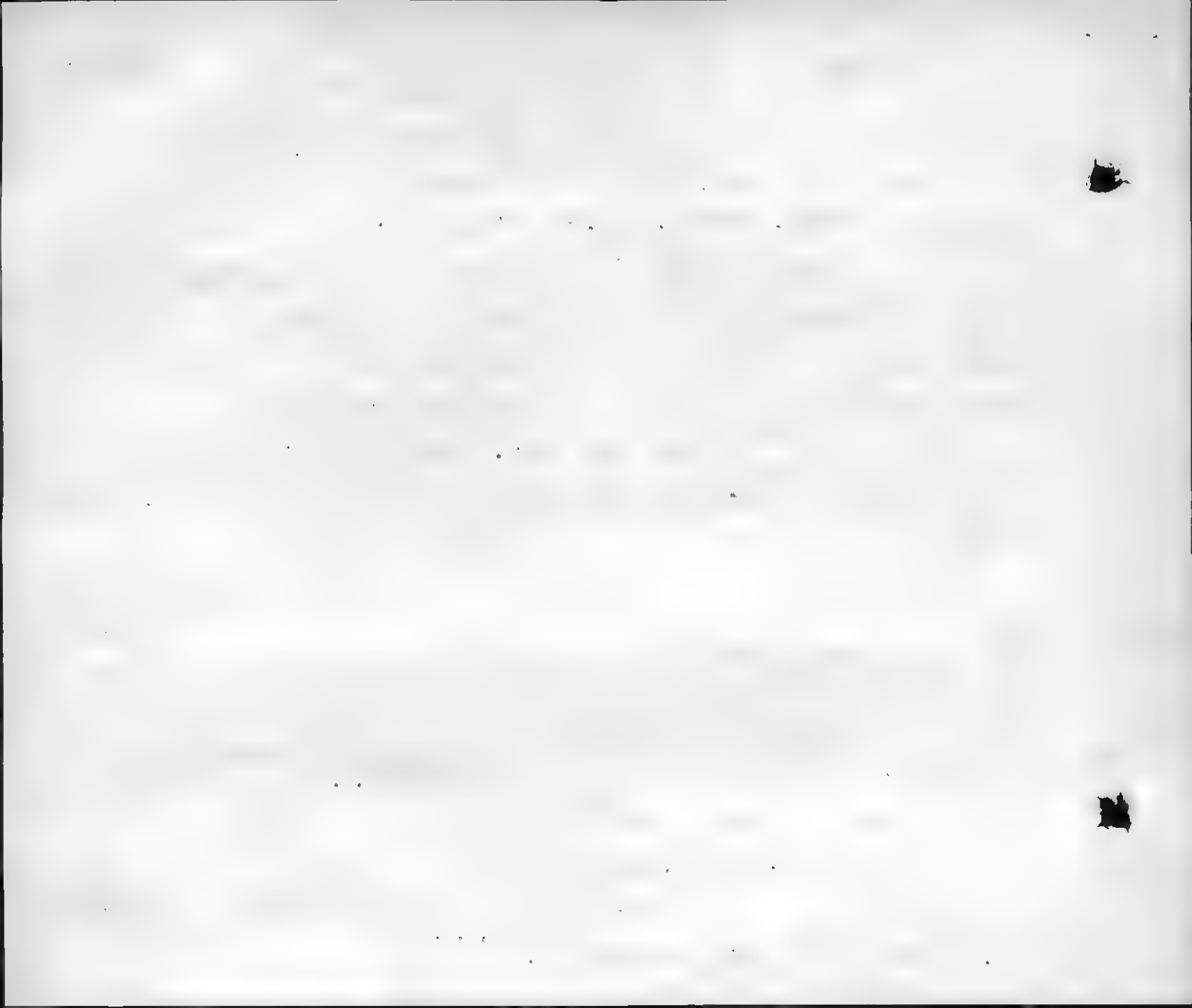
02072

Item 220, Film G200 5/1/62 iwk

CERTIFICATE OF DEATH

02054

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural) c. LENGTH OF STAY IN b 25 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland		2. USUAL RESIDENCE (Where deceased lived, if last full year; Residence before admission) a. STATE Rhode Island b. COUNTY Pawtucket c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 70 Armistice Blvd d. STREET ADDRESS 70 Armistice Blvd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN BROWN 4. DATE OF DEATH February 21, 1962		5. SEX Male 6. COLOR OR RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 28 Feb 1917 9. AGE (In years last birthday) 44 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer 11. BIRTHPLACE (County & State, or foreign country) Penna 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hawthorne Howland 14. MOTHER'S MAIDEN NAME Elizabeth Brown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 16. SOCIAL SECURITY NO. 263 60 7265 17. INFORMANT Mrs. Diana Howland (Wife) same as #2 Address 3 months	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute-leukemia-lymphocytic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 1310			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 27 January 1962 to 21 February 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 21 February 1962 , and that death occurred at 1310 M on the causes and on the date stated above.			
22a. SIGNATURE Charles E Brodine 22c. PHYSICIAN'S NAME (Type) Charles E. BRODINE, LTCDR MC USN		22b. DATE SIGNED 26 FEB 62 22d. ADDRESS WASHINGTON, D.C.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL 23b. DATE THEREOF 2/26/62		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMATORY ARLINGTON VIRGINIA 23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers 25. REGISTRAR'S SIGNATURE W.W. CHAMBERS FUNERAL HOME 1400 CHAPIN ST.		25b. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR 25c. DATE 26 FEB 62	



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MARYLAND STATE DEPARTMENT OF HEALTH

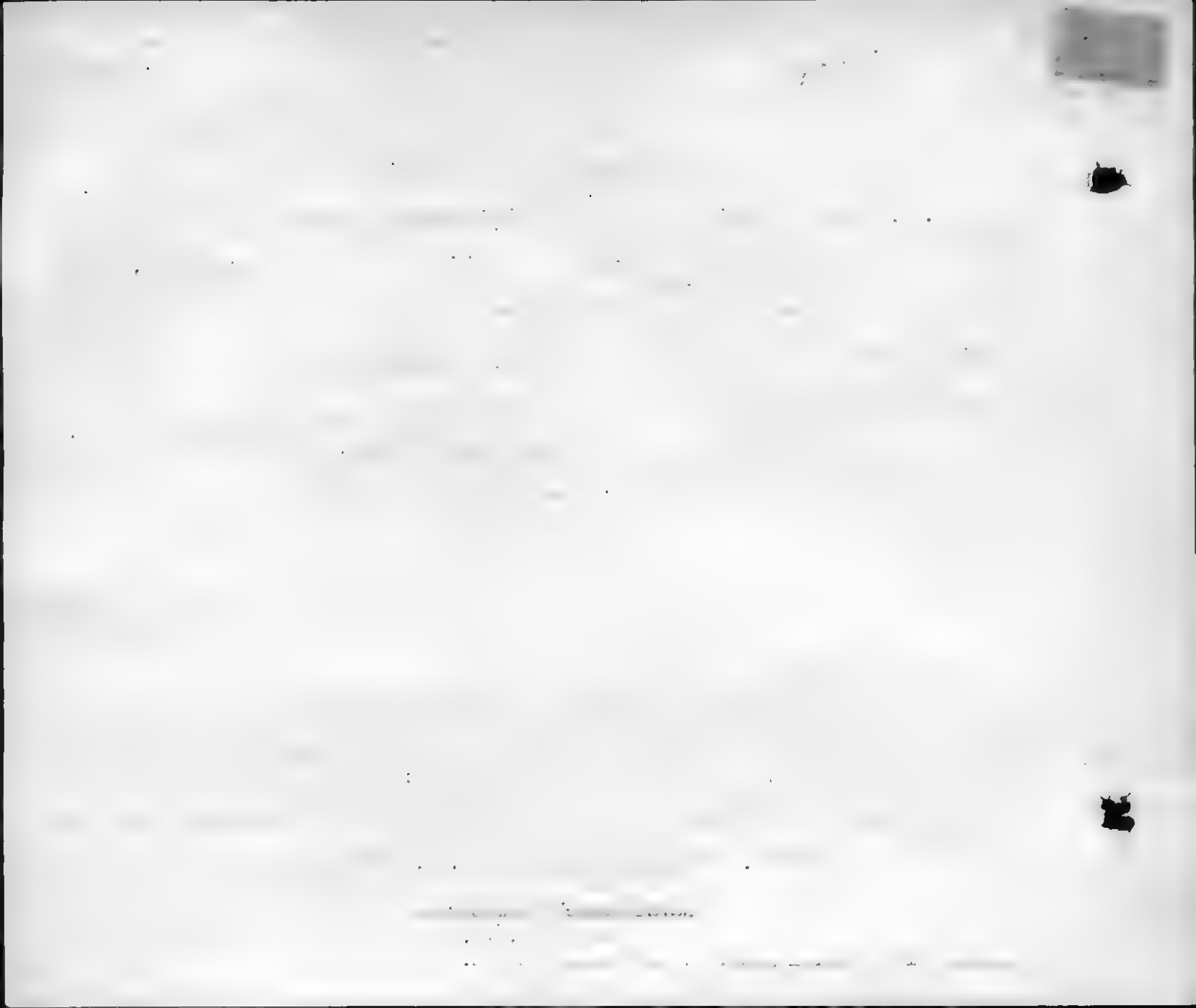
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02073

02055

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
c. LENGTH OF STAY IN 1b 26 days		d. STREET ADDRESS 125 Granville Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Vance Hull		4. DATE OF DEATH February 24, 1962	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH August 5, 1905	
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sherman Tecumseh Hull		14. MOTHER'S MAIDEN NAME Mary Hempt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Wife Elizabeth Hull, 125 Granville Ave.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Adenocarcinoma of pancreas DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)	
19. INTERVAL BETWEEN ONSET AND DEATH		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		24. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that (this hospital) attended the deceased from Jan. 30, 1962 , to Feb. 24, 1962 , that (we) last saw the deceased alive on Feb. 24, 1962 , and that death occurred at 9:15 AM from the causes and on the date stated above.			
28. SIGNATURE William P. Baker		29. DATE SIGNED February 24, 1962	
30. PHYSICIAN'S NAME (Type) WILLIAM P. BAKER, LT MC USN		31. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
32. BURIAL, CREMATION, REMOVAL (Specify) Burial		33. DATE THEREOF 2-27-62	
34. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery		35. LOCATION (City, town or county) (State) Annapolis, Maryland	
36. FUNERAL DIRECTOR'S SIGNATURE John Taylor Funeral Home		37. ADDRESS Annapolis, Md.	
38. REC'D BY REGISTRAR FEB 28 '62		39. REGISTRAR'S SIGNATURE Arthur S. House	



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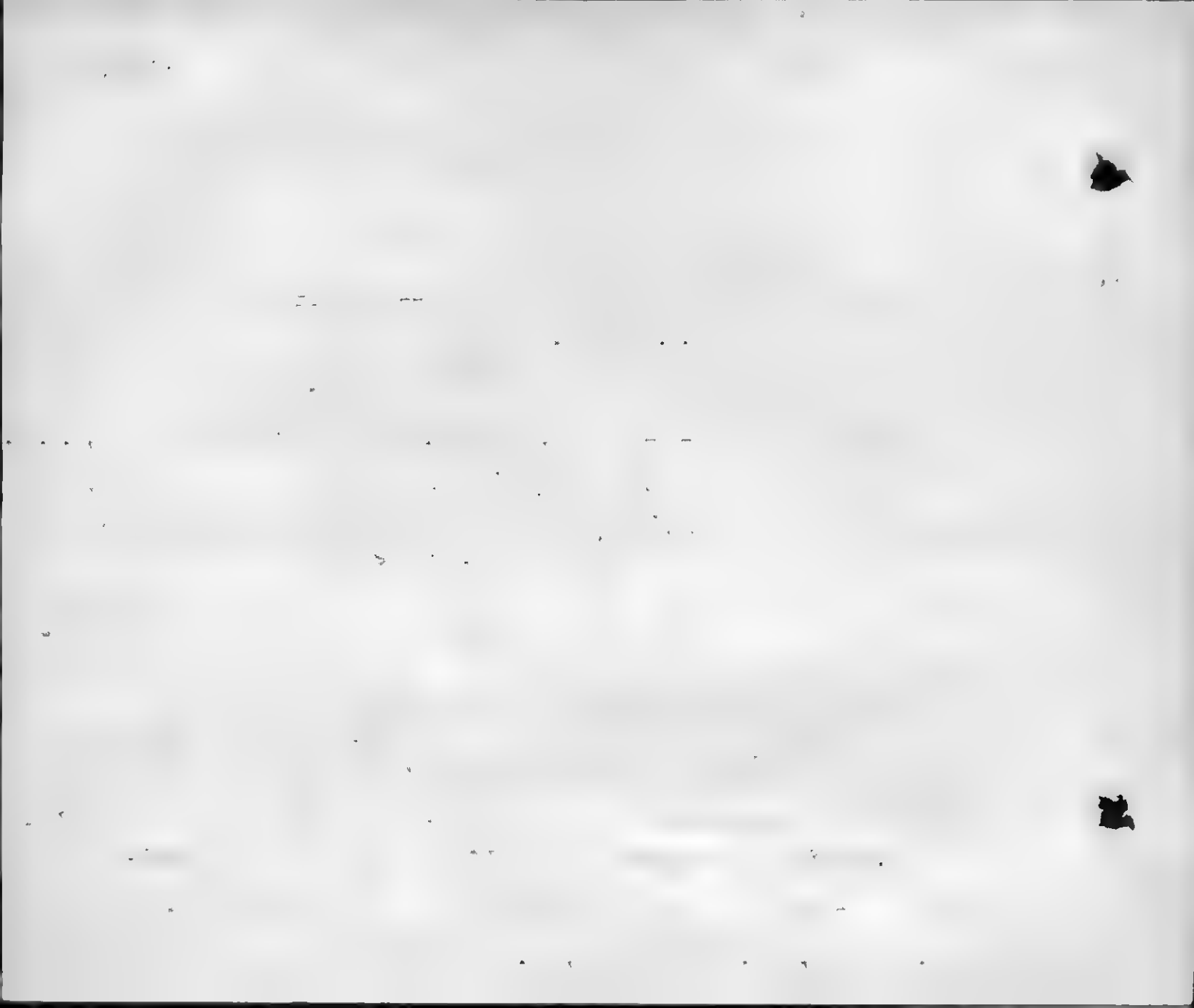
VR A15 (4)
15M 9/60

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(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
02074															
02056															
1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN b 7 days							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN HOSPITAL				e. STATE MARYLAND				f. COUNTY MONTGOMERY							
3. NAME OF DECEASED (Type or print) JOHN FRANKLIN HURDLE				4. DATE OF DEATH 2 22 19 62				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
5. SEX MALE				6. COLOR OR RACE WHITE				7. MARIED <input checked="" type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY Ed. C. Carr Co. Construction				9. AGE (In years if UNDER 1 YEAR, if UNDER 24 HRS. last birthday) Months Days Hours Min. 4/19/80 1901 50 27 yrs.							
11. BIRTHPLACE (County & State, or foreign country) WASH DC				12. CITIZEN OF WHAT COUNTRY? USA				14. MOTHER'S MAIDEN NAME ALICE A. BYLES							
13. FATHER'S NAME JOHN FRANKLIN HURDLE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. 578-01-0786				17. INFORMANT Mr. Wilbur T. Hurdle 814 Philadelphia Ave, S.S. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE ANURIA CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last, (b) CARCINOMA OF ESOPHAGUS LOWER 1/3RD MONTHS WITH METASTASES DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19															
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>															
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)															
20f. (City or town) (County) (State)															
21. I certify that (I) (his hospital) attended the deceased from 10:30 to Feb 22, 1962, that (I) (me) last saw the deceased alive on 2-21-1962, and that death occurred at 11:30 A.M. from the causes and on the date stated above.															
22a. SIGNATURE Dewitt E. DeLawyer															
22b. DATE SIGNED 2-22-62															
22c. PHYSICIAN'S NAME (Type) DEWITT E. DELAWYER															
22d. ADDRESS 8025 ABERDEEN RD. BETH. MD.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial															
23b. DATE THEREOF 2-24-62															
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery															
23d. LOCATION (City, town or county) (State) Prince Georges Co. Maryland															
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Silver Spring, Md.															
25. REC'D BY REGISTRAR DATE FEB 26 '62															
25b. REGISTRAR'S SIGNATURE															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02075

CERTIFICATE OF DEATH

02057

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dawsonville, Md</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boyd's, Md</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ada Virginia Jackson</u>				4. DATE OF DEATH Month Day Year <u>Feb 15 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 12, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Mason</u>				14. MOTHER'S MAIDEN NAME <u>May</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr Daniel T. Jackson</u> (Same as item #2)				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, Acute.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11:30 AM 15 Feb 1962</u> to <u>12:15 PM 15 Feb 1962</u> that (I) (we) last saw the deceased alive on <u>15 Feb 1962</u> and that death occurred at <u>1:45 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert L. Snowden</u>				22b. DATE SIGNED <u>15</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>Boyd's, Md.</u>			
23a. BURIAL CREMATON, REMOVAL (Specify)		23b. DATE THEREOF <u>2/19/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Clarksburg, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 21 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

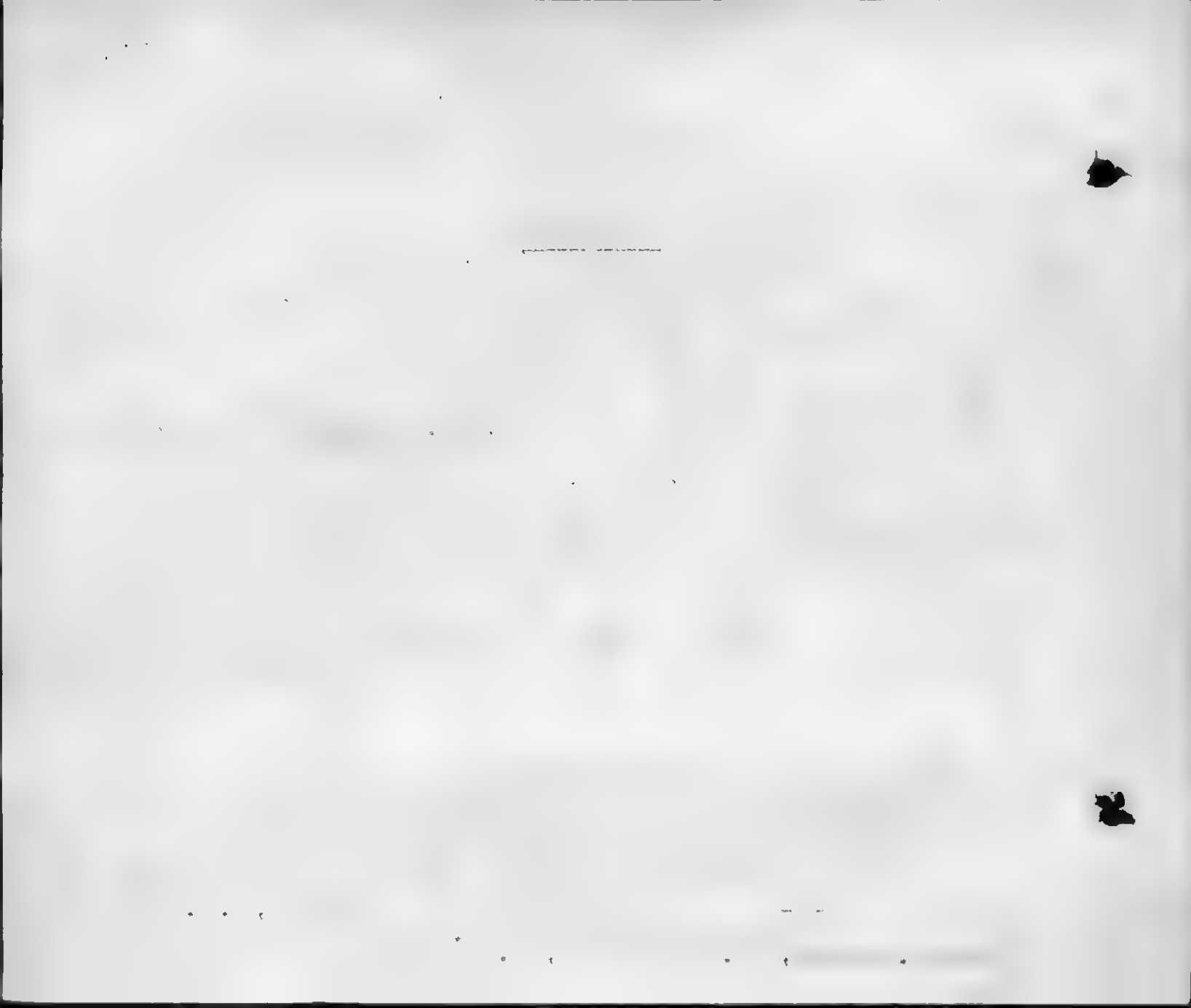
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02076

02058

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u> c. LENGTH OF STAY IN 1b <u>2-22-60</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Althea Woodland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4550 Conn. Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>ESTELLE</u> Last <u>JAMES</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>Cauc-</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13-1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC</u>
13. FATHER'S NAME <u>Dr. James R. Reilly</u>		14. MOTHER'S MAIDEN NAME <u>Alice Pywell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>Hospital records- 1000 Indiana St.</u>
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180 X</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Influenza-Viral Infection</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterial Sclerotic Heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>1 1/2 wks.</u>
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) 20h. (State)
21. I certify that (i) (this hospital) attended the deceased from <u>1959</u> to <u>Feb 15, 1962</u> that (i) (not) last saw the deceased alive on <u>Feb 14, 1962</u> and that death occurred at <u>8:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Hare</u>		22b. DATE SIGNED <u>Feb 15 1962</u>	22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-19-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		24a. ADDRESS <u>Georgia Ave. Silver Spring, Md.</u>	25a. REC'D BY REGISTRAR <u>Feb 21 '62</u>
25b. REGISTRAR'S SIGNATURE <u>W. S. Hume</u>		25c. LOCATION (City, town or county) <u>Washington, D. C.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02059

02077

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY in 1b <u>2 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Reside) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>a. STATE <u>North Carolina</u></td> <td>b. COUNTY <u>Orange</u></td> </tr> <tr> <td colspan="2">c. CITY OR TOWN <u>Chapel Hill</u></td> </tr> <tr> <td colspan="2">d. STREET ADDRESS <u>Glenn Heights</u></td> </tr> </table>				a. STATE <u>North Carolina</u>	b. COUNTY <u>Orange</u>	c. CITY OR TOWN <u>Chapel Hill</u>		d. STREET ADDRESS <u>Glenn Heights</u>	
a. STATE <u>North Carolina</u>	b. COUNTY <u>Orange</u>												
c. CITY OR TOWN <u>Chapel Hill</u>													
d. STREET ADDRESS <u>Glenn Heights</u>													
3. NAME OF DECEASED (Type or print) <u>ROLF JOHANNESSEN</u>		4. DATE OF DEATH Year <u>1962</u> Month <u>2</u> Day <u>26</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH <u>7-1-94</u>		9. AGE (in years last birthday) <u>67</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u>									
11. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>15</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Professor</u>									
11. BIRTHPLACE (County & State, or foreign country) <u>SKien Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA Since 1918</u>		14. MOTHER'S MAIDEN NAME <u>MAJA LARSEN</u>									
13. FATHER'S NAME <u>HARTVIG JOHANNESSEN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>Wife - SAME AS ABOVE</u>									
17. INFORMANT <u>Wife - SAME AS ABOVE</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hemorrhagic enteritis, cause?</u> DUE TO (b) <u>571.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>571.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2d</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Atherosclerotic heart disease</u>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) <u>2/23/62</u>		20g. (County) <u>2/26/62</u>		20h. (State) <u>2/26/62</u>									
21. I certify that (I) (this hospital) attended the deceased from <u>2/23/62</u> to <u>2/26/62</u>, that (I) <u>last</u> saw the deceased alive on <u>2/26/62</u>, and that death occurred at <u>1A</u> AM, from the causes and on the date stated above.													
22a. SIGNATURE <u>Marvin Wadler</u>		22b. DATE SIGNED <u>2/26/62</u>		22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>									
22d. ADDRESS <u>8218 Wisconsin Ave., Bethesda, Md.</u>		23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Cremation 2/27/62</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) <u>Suitland, Maryland</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 1 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Carl H. S. Kraus</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

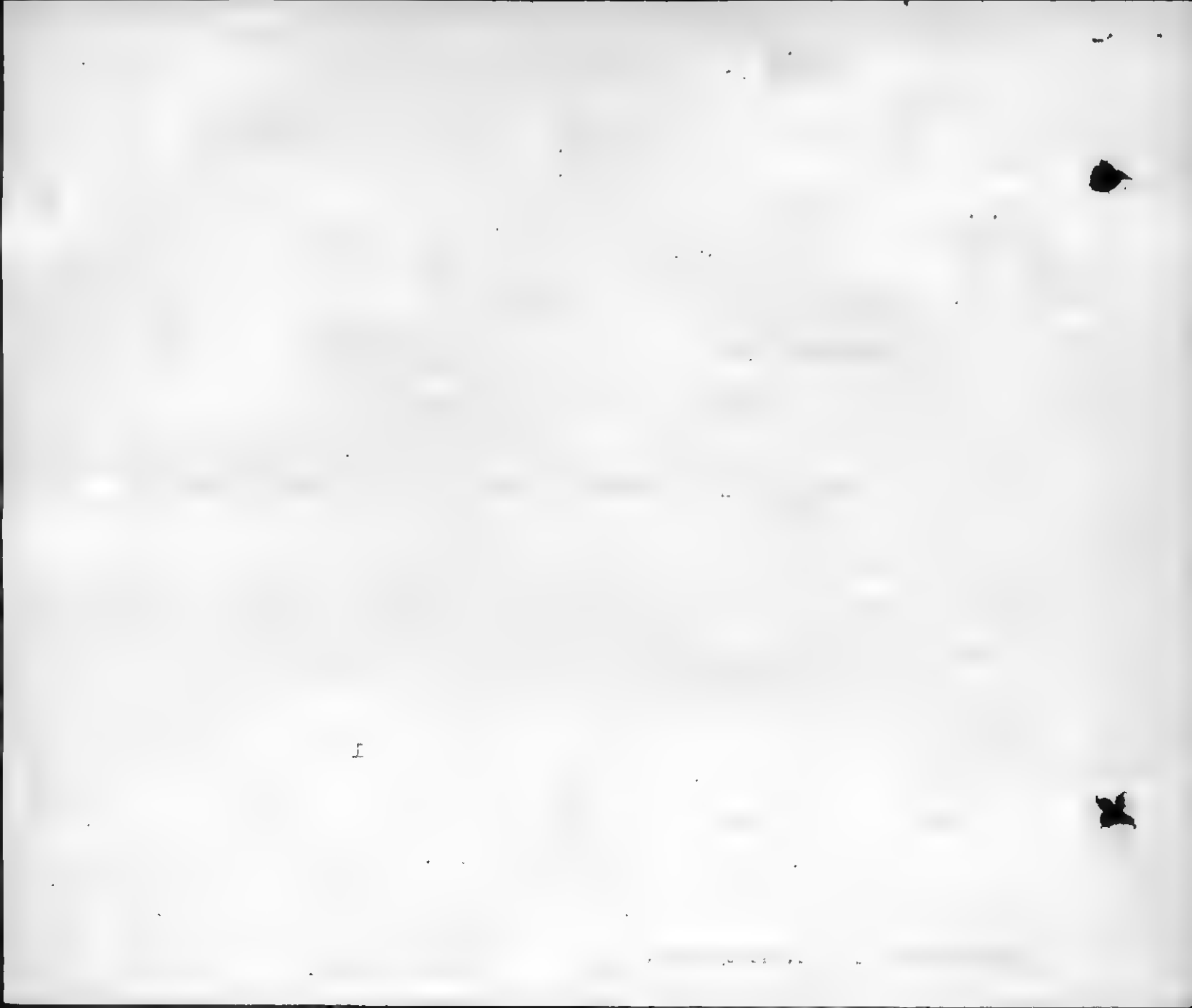


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7, 61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02078											
Item 23b Film G308 3/9/62 mb											
02060											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 74 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Harrisburg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harrisburg d. STREET ADDRESS 505 Wiconisco, Apt. #3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Arthur Middle Fritchhoff Last Johnson				4. DATE OF DEATH February 28 19 62				9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS: Hours 0 Min. 0			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1898		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Corps Officer		11. BIRTHPLACE (County & State, or foreign country) Massachusetts	
13. FATHER'S NAME Alex Johnson				14. MOTHER'S MAIDEN NAME Ellen Nelson				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. Wife: Mrs. Mary G. Johnson, Same as #2				17. INFORMANT Address Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Adenocarcinoma of pancreas with wide spread metastasis 157X DUE TO Adenocarcinoma of pancreas with wide spread metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of pancreas with wide spread metastasis DUE TO Adenocarcinoma of pancreas with wide spread metastasis (c) Adenocarcinoma of pancreas with wide spread metastasis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of pancreas with wide spread metastasis											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 19 62 Hour a.m. 10 p.m. 0											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (this hospital) attended the deceased from Dec. 16, 19 62 to Feb. 28, 19 62 that (we) last saw the deceased alive on Feb. 28, 19 62 , and that death occurred at 4:40AM from the causes and on the date stated above.											
22a. SIGNATURE John R. Warmolts MD ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE February 28, 1962											
22c. PHYSICIAN'S NAME (Type) JOHN R. WARMOLTS LT MC USN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Mar. 5, 1962 23c. NAME OF CEMETERY OR CREMATORY National Cemetery 23d. LOCATION (City, town or county) (State) Gettysburg, Pa.											
24. FUNERAL DIRECTOR'S SIGNATURE Bender Funeral Home, Gettysburg, Pa. ADDRESS Gettysburg, Pa. 25a. REC'D BY REGISTRAR 5 '62 25b. REGISTRAR'S SIGNATURE William S. Hume											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A111 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
02079 CERTIFICATE OF DEATH 02061

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE WASHINGTON, D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D. C. 41X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WHEATON NURSING HOME				d. STREET ADDRESS 5008 5TH ST. N. W.			
3. NAME OF DECEASED (Type or print) First NEVIN Middle BENJAMIN Last JOHNSON				4. DATE OF DEATH Month 2 Day 16th Year 1962			
5. SEX MALE	6. COLOR OR RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/1900	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GEOLOGICAL SURVEY				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME WILLIAM B. JOHNSON				14. MOTHER'S MAIDEN NAME ETTA THOMAS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 305X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Alzheimer's disease, brain DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
INTERVAL BETWEEN ONSET AND DEATH terminal about 6 months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 15, 1961 to date , 19 62 , that (I) (we) last saw the deceased alive on 2-15-62 19 62 , and that death occurred at 2:55 P.M. from the causes and on the date stated above.							
22a. SIGNATURE S. G. Anagnos, M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) S. GEORGE ANAGNOS				22d. ADDRESS 1150 CONNECTICUT AVE., N.W. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		2-2-62		Georgetown		Georgetown Md	
24. FUNERAL DIRECTOR'S SIGNATURE W. R. [Signature]				25a. REC'D BY REGISTRAR FEB 19 62		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02080

Item 23a Film G507 2/21/62 - jwk

02062

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>			d. STREET ADDRESS <u>1022 East West Highway</u>		
3. NAME OF DECEASED (Type or print) <u>GRACE AGNES JOYCE</u>			4. DATE OF DEATH <u>Feb. 9 1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10-26-85</u>	9. AGE (In years last birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		
13. FATHER'S NAME <u>George R. Dunn</u>			14. MOTHER'S MAIDEN NAME <u>Agnes Daley</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NEAL Cisse</u>		
17. INFORMANT <u>NEAL Cisse</u>			Address <u>20</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>525 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fibrotic Pulmonary condition</u> (c) <u>old.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>old.</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1952</u> , to <u>Feb 9 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 9 1962</u> , and that death occurred at <u>12 M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Ernest A. Sarao</u>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Ernest A. Sarao M.D.</u>			22d. ADDRESS <u>7006 N.H. AVE, TAKOMA PK. MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>2-13-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	
23d. LOCATION (City, town or county) <u>Washington D.C.</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Haulon</u>			25a. REC'D BY REGISTRAR <u>4748 Wisconsin Ave NW - DC</u>		
25b. REGISTRAR'S SIGNATURE <u>2/14/62</u>			DATE <u>FEB 14 '62</u>		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02081

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02083

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 4005 Halsey St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Aretta M Judd		4. DATE OF DEATH February 19, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/17/27
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard Racey		14. MOTHER'S MAIDEN NAME Procene Kamer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-22-2342	
17. INFORMANT husband Donald A. Judd		Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumothorax DUE TO (b) Generalized Tetanus DUE TO (c) undifferentiated sarcoma of Left Thigh PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 12 , 1962 to Feb 19 , 1962, that (I) (we) last saw the deceased alive on Feb 18 , 1962, and that death occurred at 4:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Michael R. Doda, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Michael R. Doda, M.D.		22d. ADDRESS 10620 Georgia Ave. Silver Spring, Md.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) burial 2/22/62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION (City, town or county) Suitland, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE The S H Lines Co 2901-14 St N.W. D.C.		25a. REC'D BY REGISTRAR FEB 21 1962	
25b. REGISTRAR'S SIGNATURE Walter S. Thomas		DATE	



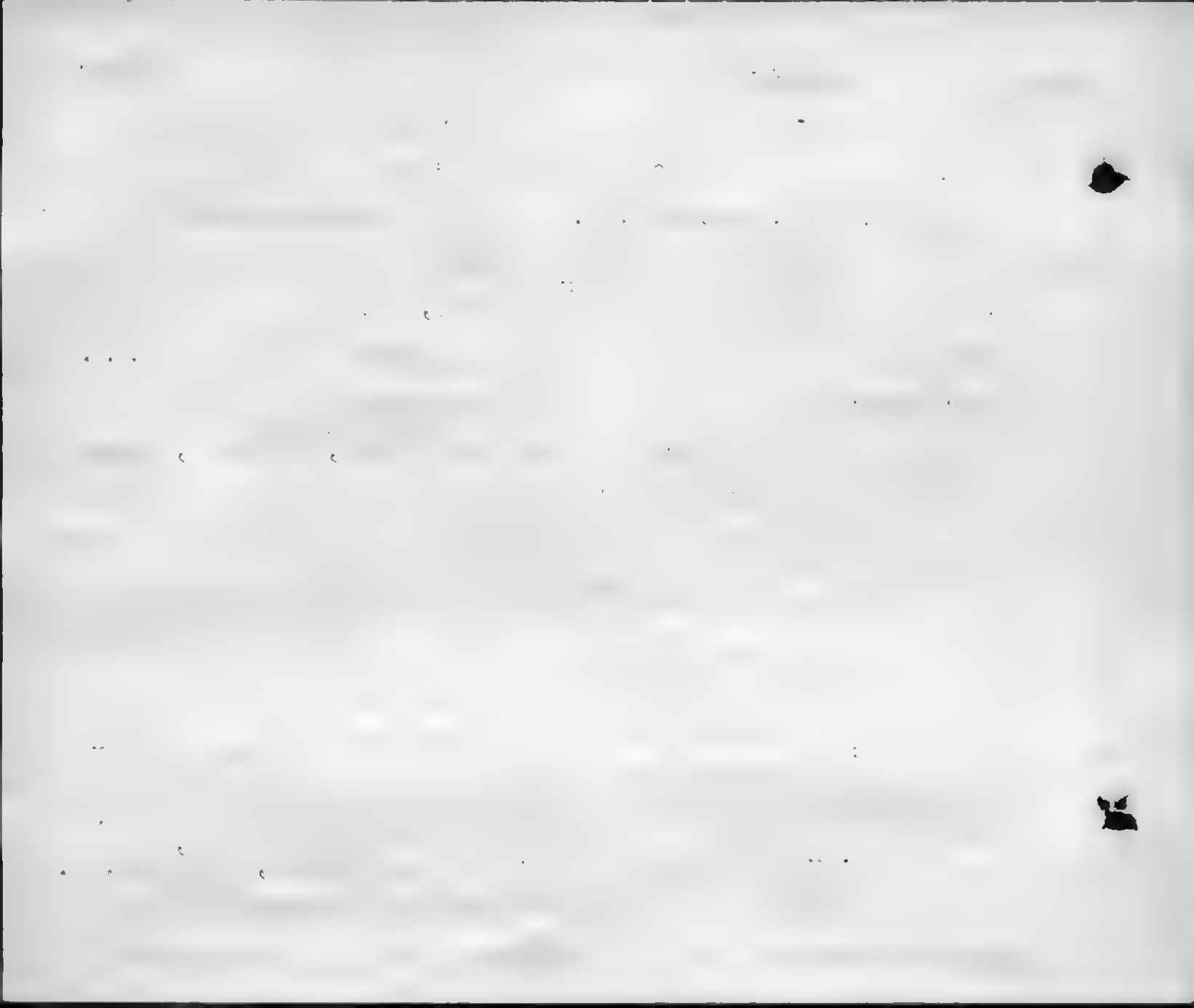
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02082

02084

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia		b. COUNTY Arlington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		d. STREET ADDRESS 1505 South Columbus Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		3. NAME OF DECEASED (Type or print) Bessie Marie Keller		4. DATE OF DEATH February 20 19 62		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 23, 1951		9. AGE (In years last birthday) 10 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (County & State, or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Keller		14. MOTHER'S MAIDEN NAME Bessie Caldwell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record		18. ADDRESS The Clinical Center, Bethesda 14, Maryland		19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 25 minutes		20. TIME OF INJURY Month, Day, Year February 18, 19 62		21. I certify that (this hospital) attended the deceased from February 18, 19 62 to February 20, 19 62 that (we) last saw the deceased alive on February 20, 19 62 , and that death occurred at 8:10 PM , from the causes and on the date stated above.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 7540 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Post operative hemorrhage DUE TO (c) Congenital heart disease, Tetralogy of Fallot		22a. SIGNATURE A. G. Morrow, M.D.		22b. DATE SIGNED February 21, 1962		22c. PHYSICIAN'S NAME (Type) A. G. Morrow		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial		23b. DATE THEREOF 7/23/62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington Va.		24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chamber Co. 3072 M St NW		25a. REC'D BY REGISTRAR FEB 23 '62		25b. REGISTRAR'S SIGNATURE William S. Kraus	



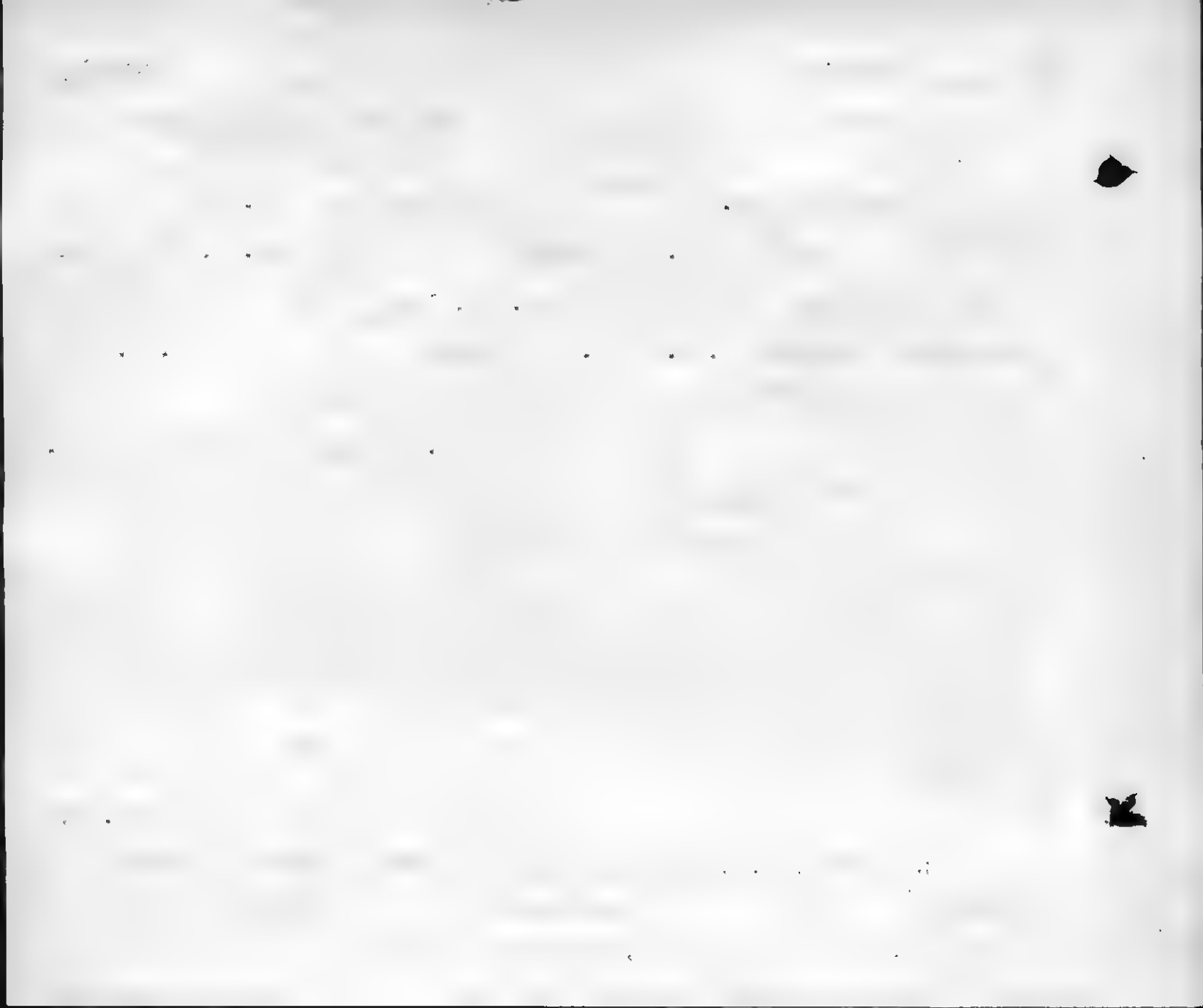
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02083											
02085											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9104 Hempstead Ave.				d. STREET ADDRESS 9104 Hempstead Ave.							
3. NAME OF DECEASED (Type or print) JOHN J. KELLEY				4. DATE OF DEATH Feb. 8, 1962				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1901		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 11 Days 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer- U. S. Govt.				10b. KIND OF BUSINESS OR INDUSTRY Penna				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME John Joseph Kelley				14. MOTHER'S MAIDEN NAME Nellie Finnegan							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. WW II				17. INFORMANT Wife Kathryn C. Kelley Address Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension Arteriosclerosis DUE TO Chronic Heart Disease & Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Infarction DUE TO (c) Infarction											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 12/26/1961 to 2/8/62 , that (I) (we) last saw the deceased alive on 2/8/1962 , and that death occurred at 2 P.M. from the causes and on the date stated above.											
22a. SIGNATURE W. T. Joyce, M.D.											
22b. DATE Feb. 9/62											
22c. PHYSICIAN'S NAME (Type) W. T. Joyce, M.D.											
22d. ADDRESS 8106 Maple Ridge Road, Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 2/13/1962											
23c. NAME OF CEMETERY OR CREMATORY Arlington National											
23d. LOCATION (City, town or county) (State) Arlington Virginia											
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland											
25a. REC'D BY REGISTRAR Feb 13 '62											
25b. REGISTRAR'S SIGNATURE Lincoln S. Thomas											



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02084

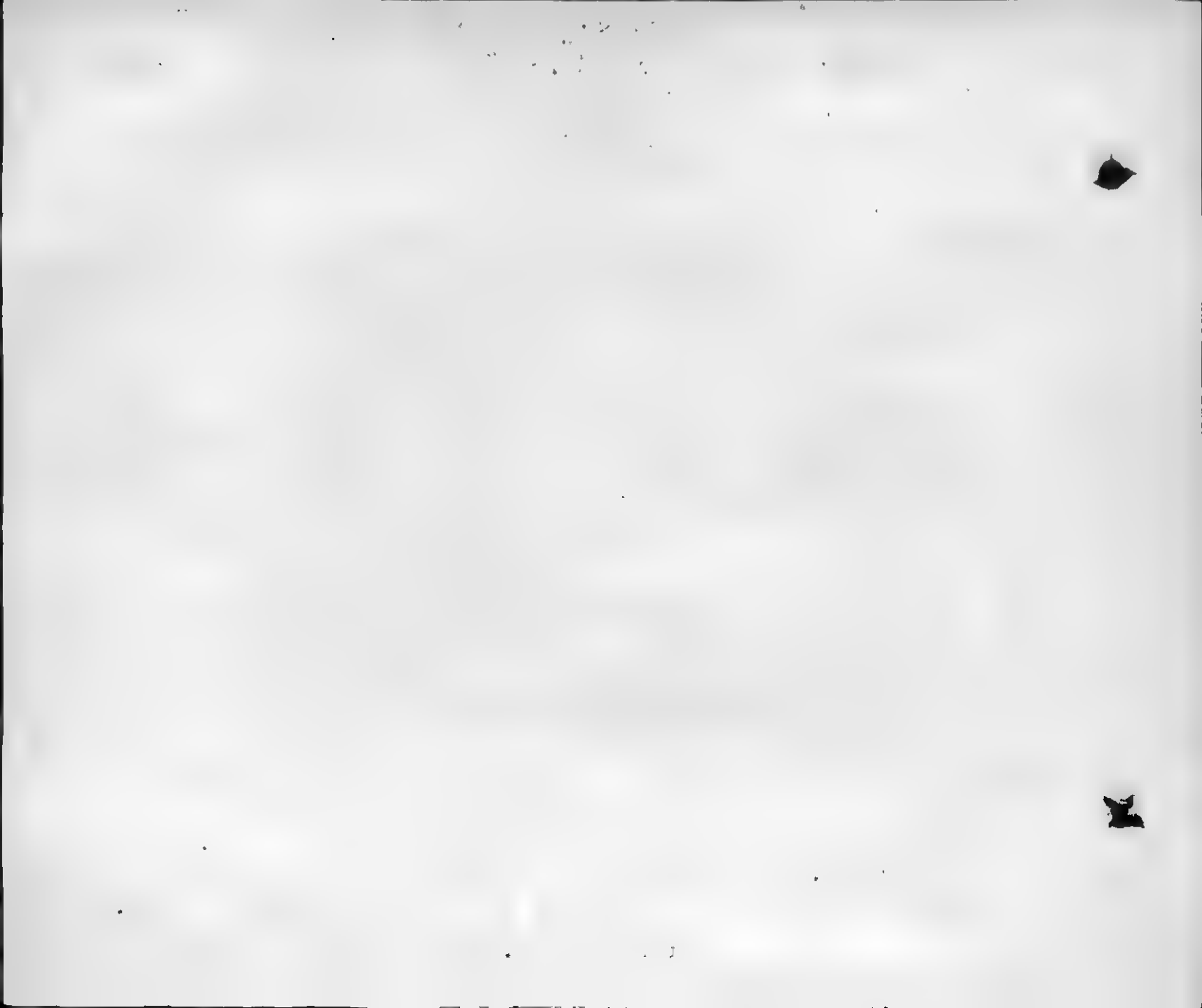
02066

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if first funeral residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>10010 Sidney Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Lee</u> Last <u>Kemp</u>		4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 27 1907</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Edward Kemp</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Day</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Stanley Kemp</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute coronary occlusion</u> DUE TO (c) <u>Hemorrhage into myocardial plaque</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>Feb. 12, 1962</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb, 15 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or country) (State) <u>Gaithersburg Md.</u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>		24a. REC'D BY REG. STRAR <u>Feb 15 '62</u>	
ADDRESS <u>Laytonsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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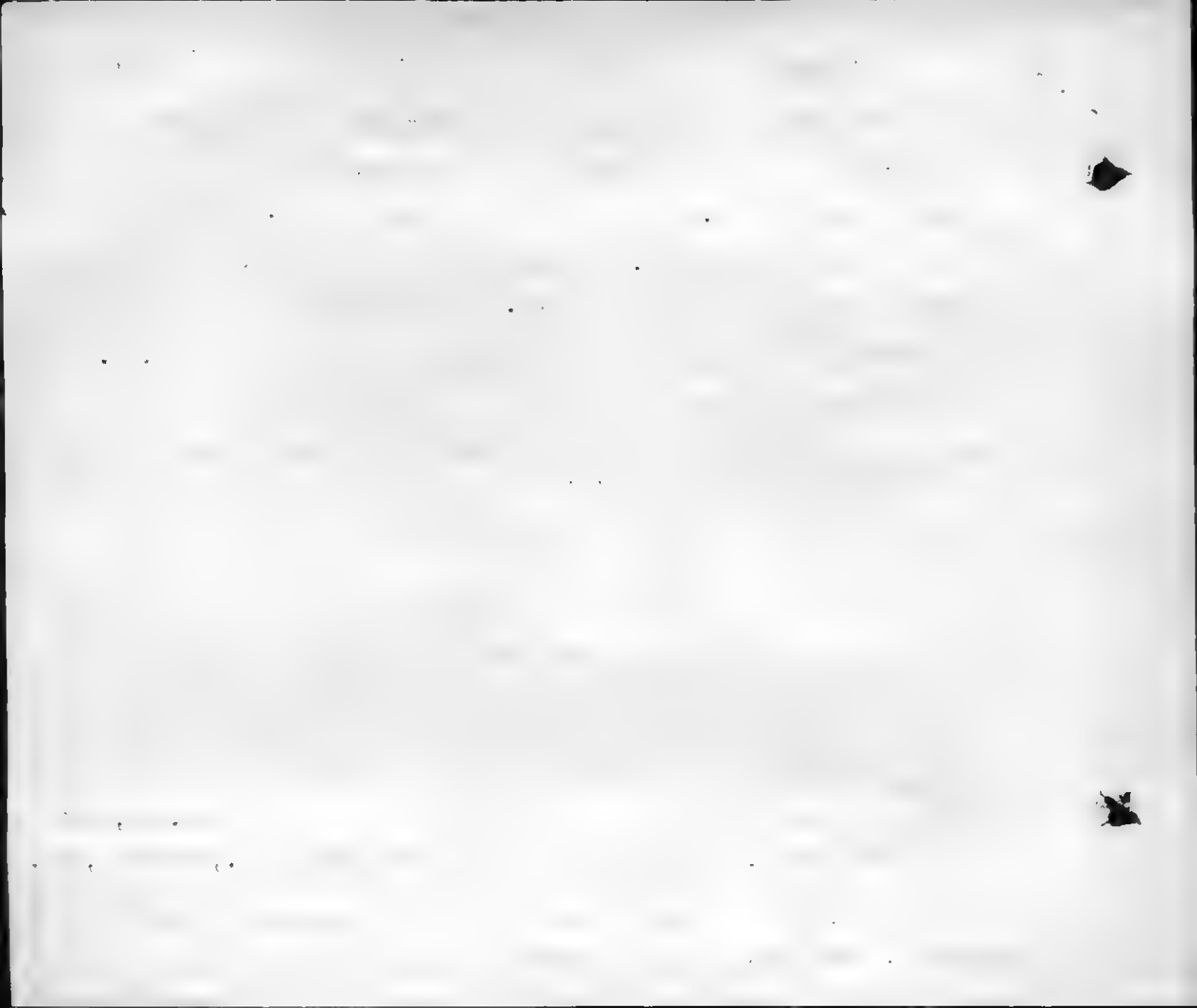
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02085

02067

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN TB 30 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6307 Bells Mill Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6307 Bells Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) BLANCH L. KERWIN	4. DATE OF DEATH Feb. 19 19 62	5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 25, 1892 9. AGE (In years last birthday) 69 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Iowa 11. BIRTHPLACE (County & State, or foreign country) U. S. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Joseph Lytle 14. MOTHER'S NAME Adaline Hall 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Charles Kerwin-Husband-same 2d 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 411X Conditions, if any, which gave rise to immediate cause (b) Arter. Sclerosis DUE TO Rheumatic Heart Disease cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH 5 yr 20 yr		
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb 15 1962 to Feb 19 1962 that (I) (we) last saw the deceased alive on Feb 15 1962 and that death occurred at 1:30 P.M. from the causes and on the date stated above.				
22e. SIGNATURE 22c. PHYSICIAN'S NAME (Type) WILLIAM H. KILLAY		22b. DATE SIGNED Feb. 19, 1962 22d. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/23/62	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. 23d. LOCATION (City, town or county) Arlington, Virginia (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR Feb 23 1962 25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02086

CERTIFICATE OF DEATH

02068

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 89 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1908 Florida Avenue, N.W. d. STREET ADDRESS 47X-2							
3. NAME OF DECEASED (Type or print) Female 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Mgr. Apt. House 10b. KIND OF BUSINESS OR INDUSTRY Real Estate		8. DATE OF BIRTH July 21, 1892 9. AGE (In years, last birthday) 69 yrs. 11. BIRTHPLACE (County & State, or foreign country) Texas 12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Sentell 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No 16. SOCIAL SECURITY NO 579-22-1440		14. MOTHER'S MAIDEN NAME Frances Matthew 17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatocellular liver damage and jaundice </td> <td style="width: 10%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH 2 months </td> </tr> <tr> <td> CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Small bowel-perineal fistula </td> <td style="text-align: center;"> 2 months </td> </tr> <tr> <td> (c) Recurrent carcinoma of cervix </td> <td style="text-align: center;"> 14 years </td> </tr> </table>				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatocellular liver damage and jaundice	INTERVAL BETWEEN ONSET AND DEATH 2 months	CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Small bowel-perineal fistula	2 months	(c) Recurrent carcinoma of cervix	14 years
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatocellular liver damage and jaundice	INTERVAL BETWEEN ONSET AND DEATH 2 months								
CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Small bowel-perineal fistula	2 months								
(c) Recurrent carcinoma of cervix	14 years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<table style="width: 100%;"> <tr> <td style="width: 30%;"> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> </td> <td style="width: 70%;"> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) </td> </tr> <tr> <td> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 </td> <td> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> </td> </tr> <tr> <td> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) </td> <td> 20f. (City or town) (County) (State) </td> </tr> </table>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)								
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 17, 1961 to February 14, 1962 that (I) (we) last saw the deceased alive on February 14, 1962 , and that death occurred at 11:20 PM from the causes and on the date stated above.									
22a. SIGNATURE J. Kent Trinkle 22c. PHYSICIAN'S NAME (Type) J. Kent Trinkle, M.D. 22b. DATE SIGNED 2/15/62									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 19 FEB. 1962 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL 23d. LOCATION (City, town or county) ARLINGTON VA.									
24. FUNERAL DIRECTOR'S SIGNATURE Russell Funeral Home 25a. REC'D BY REGISTRAR DATE FEB 16 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18. 4. 4. 2. 1.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02087

02069

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived) (If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Coltons Point			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS None 12903 Parkland Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles First Parker Middle Kienle Last				4. DATE OF DEATH Feb. Month 14 Day 19 Year 62			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/14/90		9. AGE (in years last birthday) yrs 71	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - driver		10b. KIND OF BUSINESS OR INDUSTRY District transit		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William G. Kienle				14. MOTHER'S MAIDEN NAME Elizabeth Medley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-10-5428		17. INFORMANT Address Laura K. Kienle 12,903 Parkland Dr. Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Carcinoma of liver & metastases DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/5/1962 to 2/14/1962 , that (I) (we) last saw the deceased alive on 2/13/1962 and that death occurred at 2 AM , from the causes and on the date stated above.							
22a. SIGNATURE <i>W. T. Joyce</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) William T. Joyce, M. D.	
				22d. ADDRESS 8106 Maple Ridge Rd. Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-62		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City, town, or county) (State) Silver Spring Montgomery Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Pumphrey</i>				25a. REC'D BY REGISTRAR DATE FEB 19 '62		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Pumphrey</i>	
Werner E. Pumphrey, Inc. Silver Spring, Md.							

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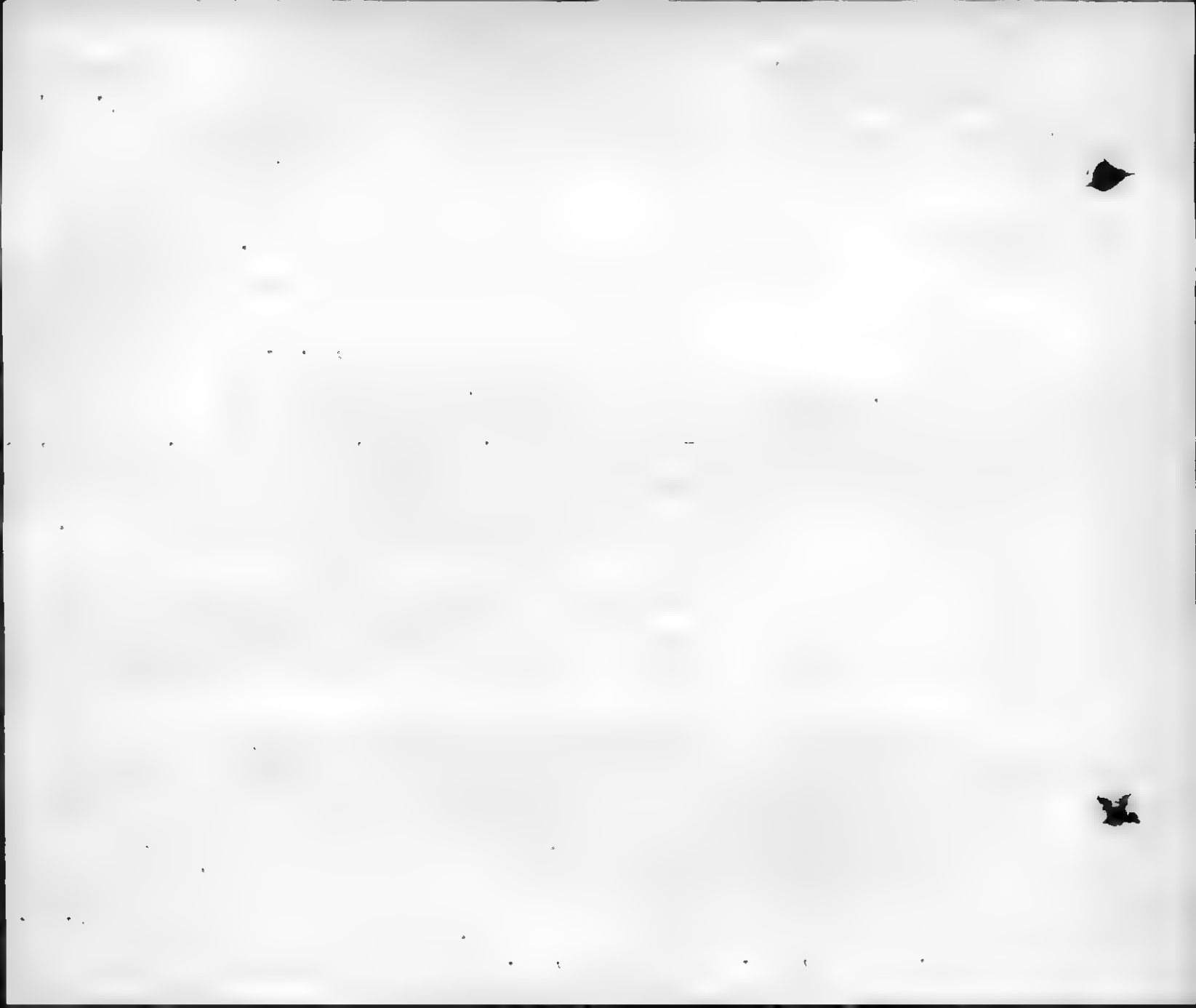
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event within 72 hours after death.

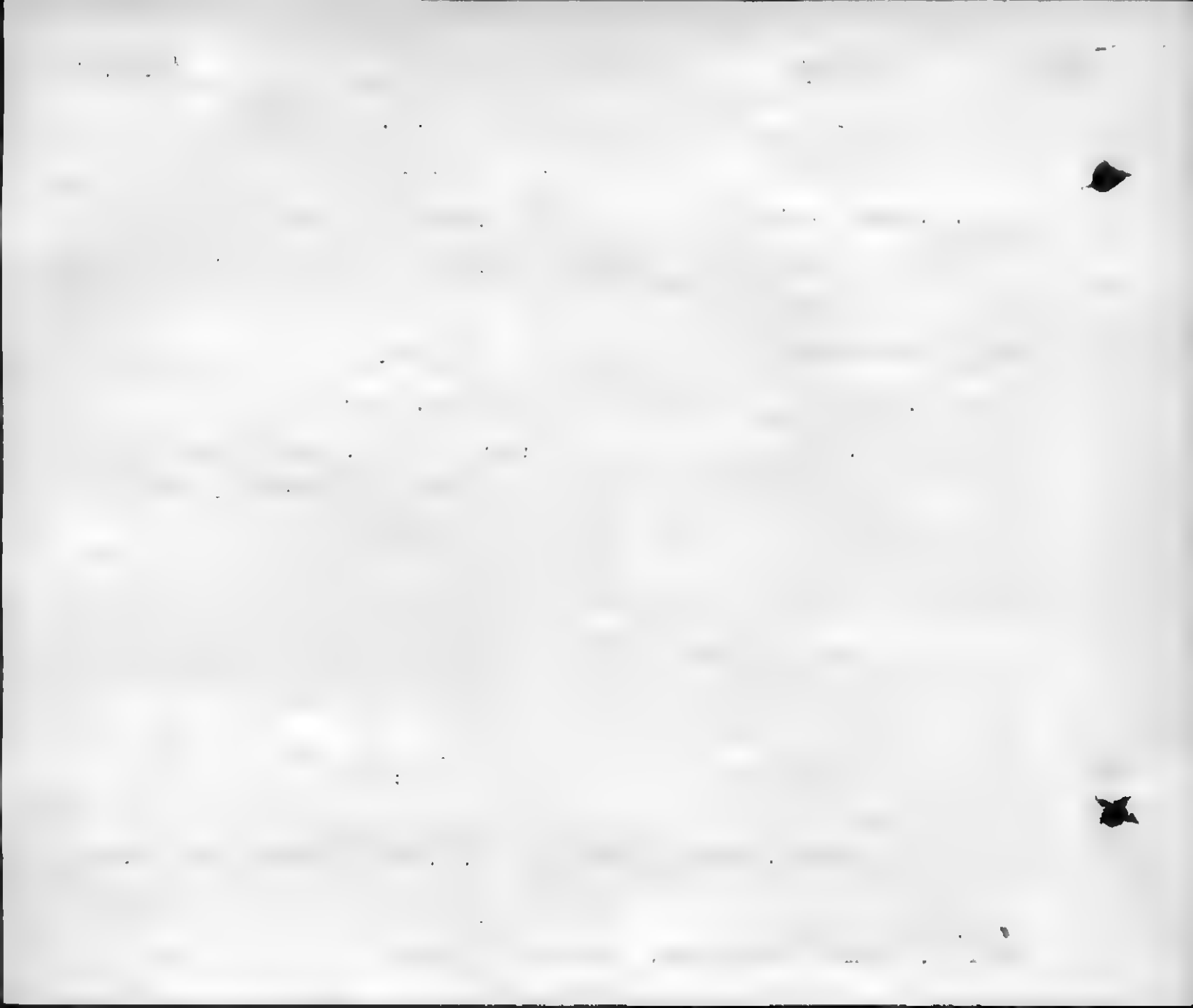
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

02088

02070

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 23 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3024 Tilden Street NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cyrus Baker Kitchen		4. DATE OF DEATH Month Day Year February 15, 1962	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY New York	
13. FATHER'S NAME Cyrus B. Kitchen		14. MOTHER'S MAIDEN NAME Ellie L. French	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I, WW II		16. SOCIAL SECURITY NO. Wife: Mrs. Dickey K. Kitchen, Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 22, 1962 , to Feb. 15, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 15, 1962 , and that death occurred at 1:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Howard A. Pearson M.D. 22c. PHYSICIAN'S NAME (Type) HOWARD A. PEARSON LCDR MC USN		22b. DATE SIGNED February 15, 1962 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-19-62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey 24b. ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR Feb 19 1962 25b. REGISTRAR'S SIGNATURE Charles L. Thomas	



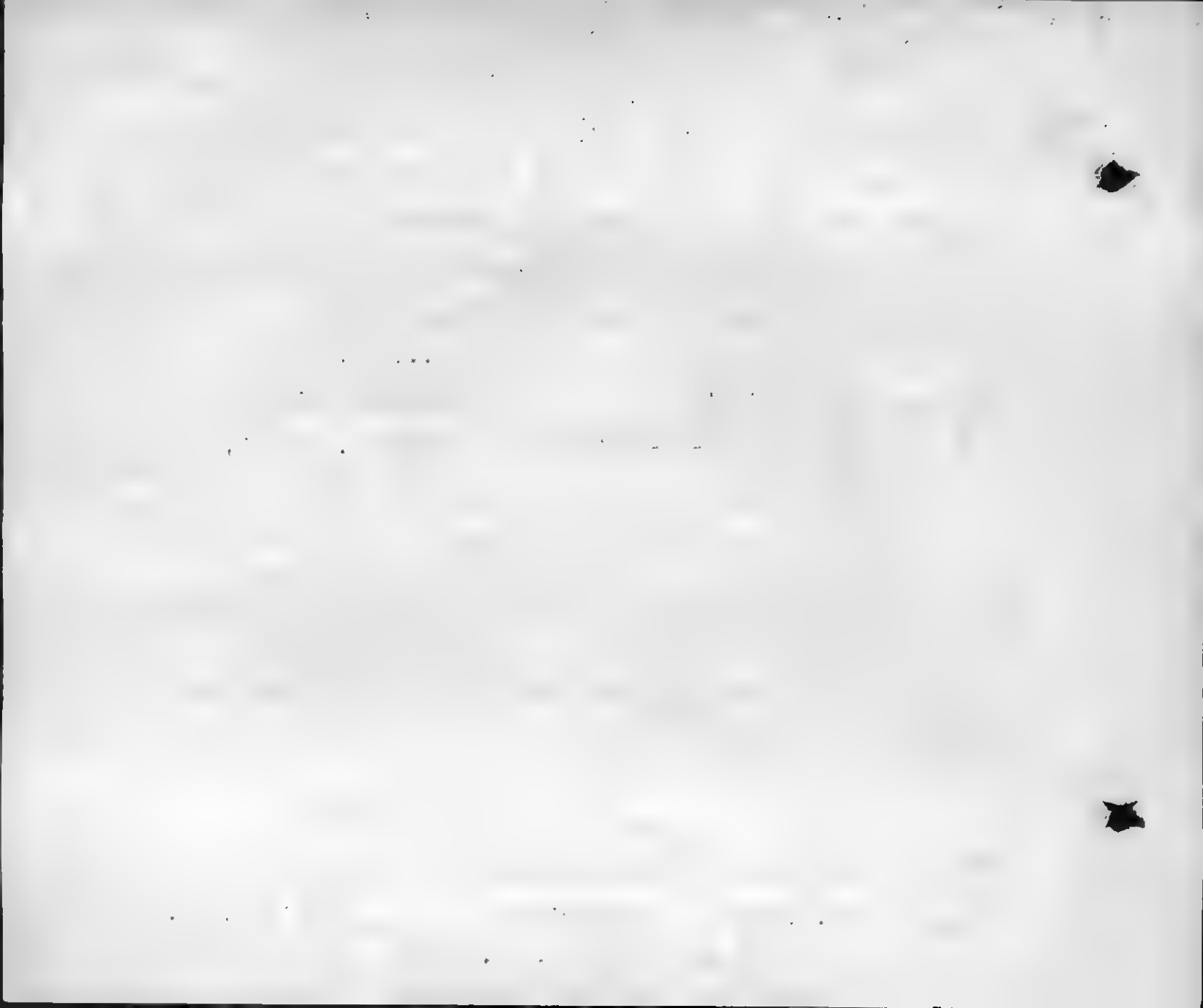
6 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02089 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02071

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> c. LENGTH OF STAY IN 1b <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pleasant Plain Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> d. STREET ADDRESS <u>Pleasant Plain Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Lee Knight</u> First Last Middle 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-21-1926</u> 9. AGE (In years last birthday) <u>36</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sgt. Md. State Police</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Mo., St. Louis</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		4. DATE OF DEATH <u>2-4-1962</u> Month Day Year 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>William Henry Knight</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW 2</u> 16. SOCIAL SECURITY NO. <u>219-18-9307</u> 17. INFORMANT <u>Mrs Jacquelyn P. Knight, Item 2</u> Address		14. MOTHER'S MAIDEN NAME <u>Mary Helen Weimeister</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>bullet wound thru left chest (heart)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted 32 cal bullet wound</u> 20c. TIME OF INJURY Month, Day, Year <u>10:15 am 2-4-1962</u> 20d. INJURY OF CURR. While <input type="checkbox"/> No While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Damascus</u> (County) <u>Montg</u> (State) <u>md</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>2-4-62</u>		DATE SIGNED <u>2-4-62</u>	
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Feb. 7, 1962</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u> Address <u>Damascus, Md.</u>		22d. LOCATION (City, town, or country) <u>Elkridge, Md.</u> 24a. REC'D BY REGISTRAR <u>FEB 8 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Wm L. Funch</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

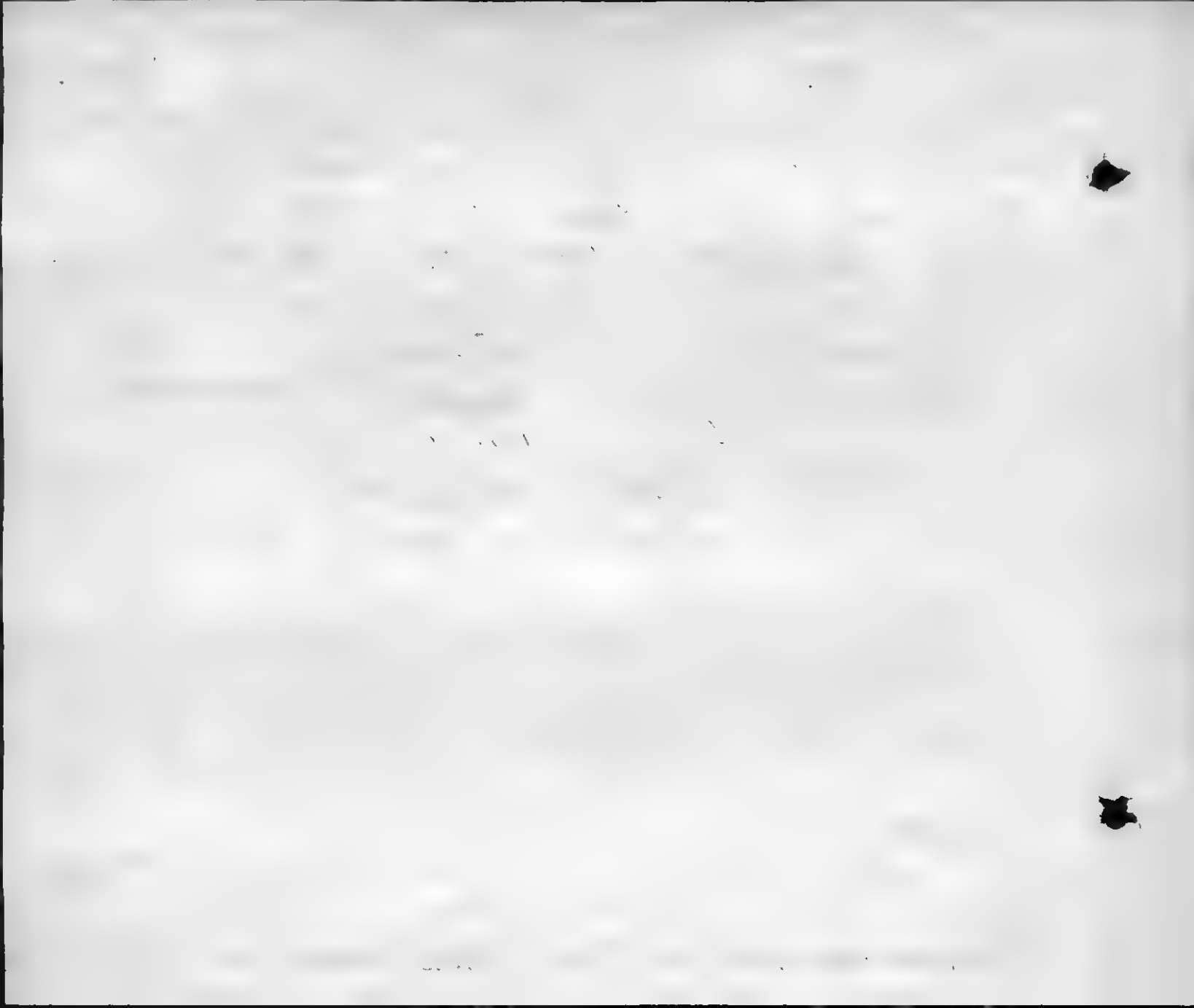
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

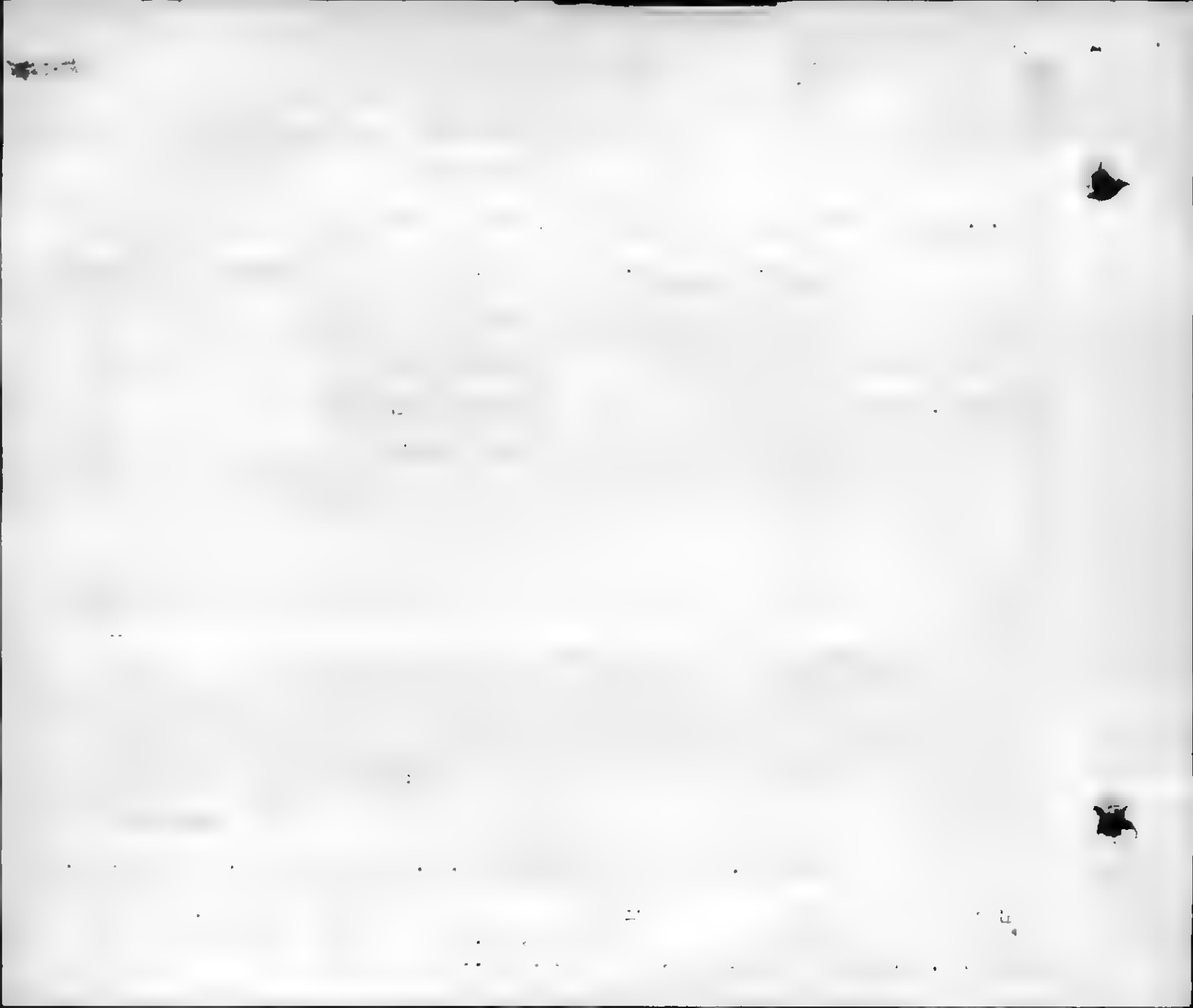
02090

02072

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>1315 Iris St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH - KRUEGER</u> First Middle Last		4. DATE OF DEATH <u>February 21 1962</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>JULY 14, 1882</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE MAID</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State or foreign country) <u>GERMANY</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HENRY KRUEGER</u>		14. MOTHER'S MAIDEN NAME <u>ANNA KRUEGER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>1086-26-2140</u> 17. INFORMANT <u>Hospital Records</u> Address <u> </u>		18. CAUSE OF DEATH (Enter only one cause per line for a) (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> Conditions, if any, which gave rise to immediate cause (b) <u>Adenocarcinoma of colon.</u> (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18, OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)) <u> </u>		20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1960</u> to <u>21 Feb 1962</u> , that (I) (we) last saw the deceased alive on <u>20 Feb 1962</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Samuel T. Kimble</u> 22c. PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE</u> 22d. ADDRESS <u>927 Pershing Ave., Silver Spring, Md.</u> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/> 22h. DATE SIGNED <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>23 Feb. 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>FOREST LAWN CEMETERY</u> 23d. LOCATION (City, town or county) <u>BUFFALO, N.Y.</u> (State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Kimble Funeral Home</u> 25. REC'D BY REGISTRAR <u>FEB 23 '62</u> 25b. REGISTRAR'S SIGNATURE <u> </u>	



1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm'ission) a. STATE VIRGINIA b. COUNTY ARLINGTON	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ARLINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. NAVAL HOSPITAL		d. STREET ADDRESS 2623 MILITARY ROAD	
3. NAME OF DECEASED (Type or print) John G. LAKE		4. DATE OF DEATH FEBRUARY 8 1962	
5. SEX MALE		6. COLOR OR RACE CAUC	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 FEB 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN T. LAKE		14. MOTHER'S MAIDEN NAME EDWINA KIMPLINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 7545 CONGENITAL HEART DISEASE IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 7, 1962 , to Feb. 8, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 8, 1962 , and that death occurred at 2:55 PM from the causes and on the date stated above.			
22a. SIGNATURE Bernard H. Feldman		22b. DATE SIGNED February 9, 1962	
22c. PHYSICIAN'S NAME (Type) BERNARD H. FELDMAN LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-12-62	
23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City, town or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE 13 '62	
25b. REGISTRAR'S SIGNATURE Robert S. Pumphrey		25c. REGISTRAR'S NAME Robert S. Pumphrey	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

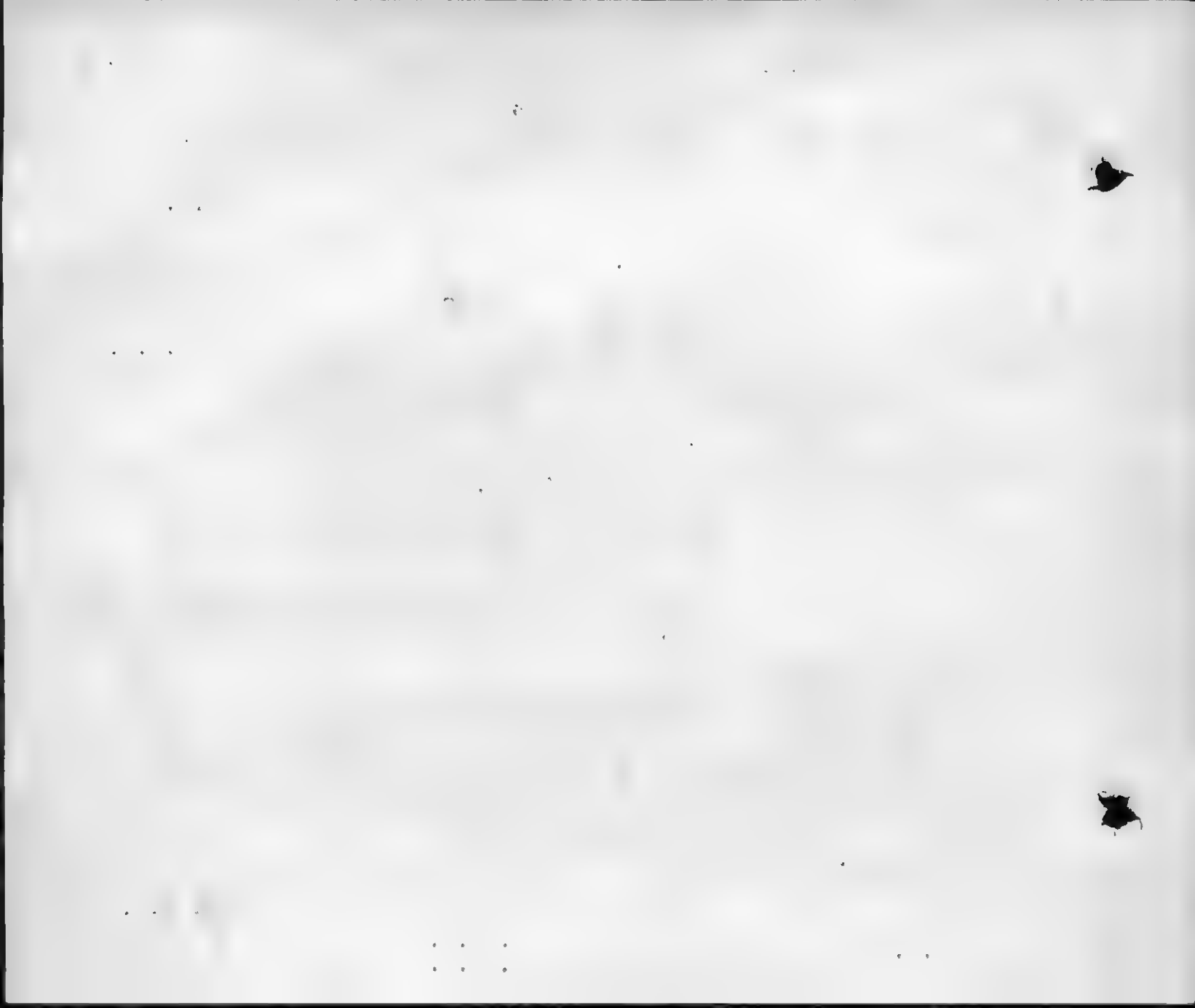
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02092

02074

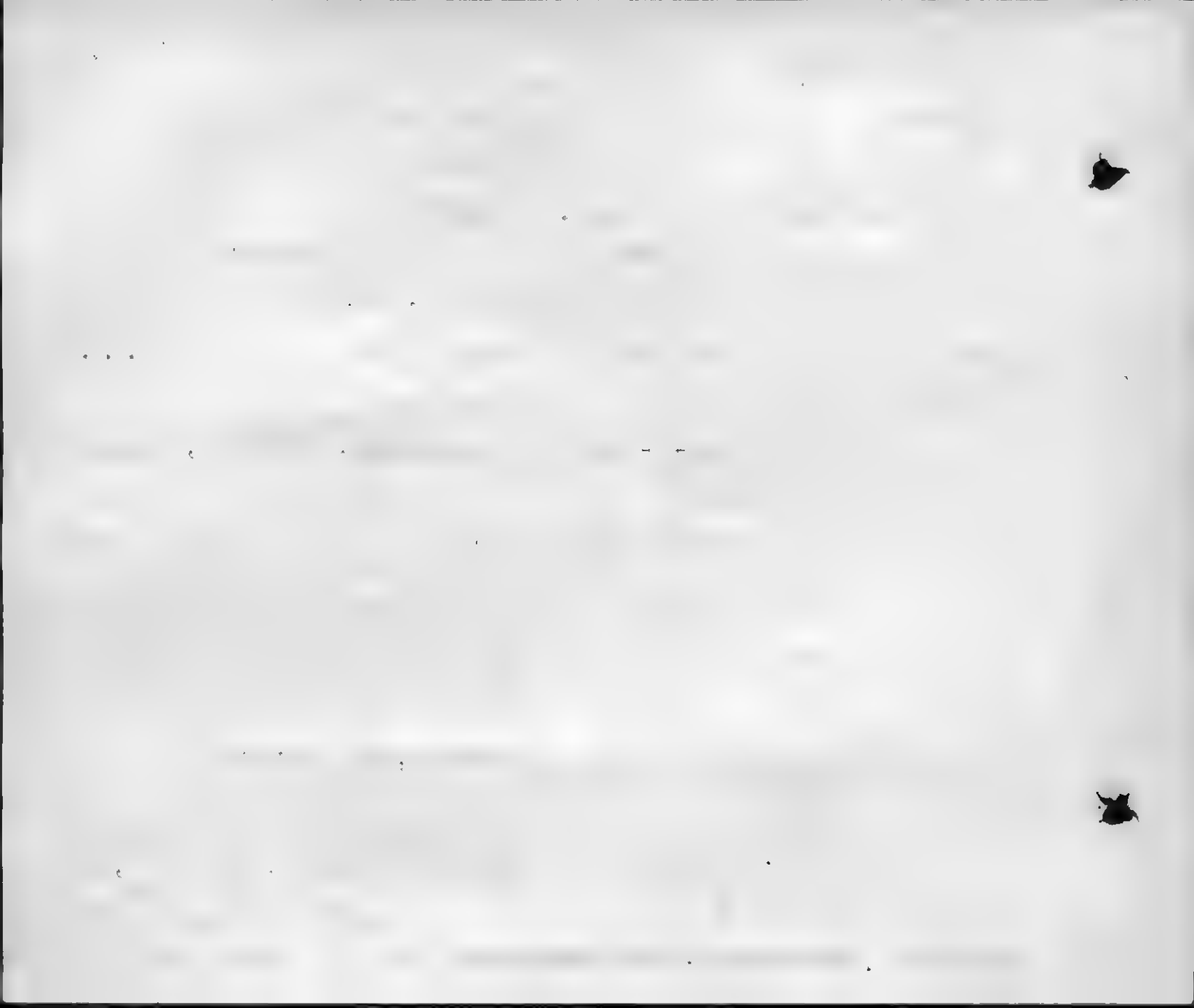
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Hall Sanitarium</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>1300 Floral Street N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>GEORGE C. LAMBROS</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>28</u> Year <u>1962</u>		5. SEX <u>M</u>	
6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/28/87</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired owner Show Boat Restaurant</u>		11. BIRTH-PLACE (County & State, or foreign country) <u>GREECE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christos Lambros</u>		14. MOTHER'S MAIDEN NAME <u>Aspasia Papanoreou</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Harry Lambros</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>ESSENTIAL HYPERTENSION</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO <u>CHRONIC PROSTATITIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC PROSTATITIS</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUG. 14, 1959</u> to <u>FEB. 28, 1962</u> that (I) (we) last saw the deceased alive on <u>FEB. 28, 1962</u> and that death occurred at <u>2:45 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Henry M. Lowden</u>					
22b. PHYSICIAN'S NAME (Type) <u>Henry M. Lowden</u>					
22c. ADDRESS <u>5206 NORWAY DR. CHEVY CHASE, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/2/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	
23d. LOCATION (City, town or county) <u>Washington, D.C.</u>		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>					
25a. ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>					
25b. DATE <u>2/62</u>					



1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2
 MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02093		Items 23 Film GSUS 2/2/62 ink							
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE North Carolina				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clayton				
c. LENGTH OF STAY IN IL 14 days					d. STREET ADDRESS Route #2				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.									
3. NAME OF DECEASED (Type or print) First Middle Last Fab Goldes Lee			4. DATE OF DEATH Month Day Year February 22 19 62		a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 12, 1901		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agricultural		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Haff Lee				14. MOTHER'S MAIDEN NAME Cora Watson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 738-56-5507					
17. INFORMANT The Medical Record				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebra Hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Acute Myelocytic Leukemia DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 24 hours 5 months					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Smithfield		(State) N.C.	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 8, 19 62 to February 22, 19 62 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 22, 19 62, and that death occurred at 7:00 PM, from the causes and on the date stated above.									
22a. SIGNATURE Robert H. Levin, M.D.				22b. DATE February 23, 19 62				22c. PHYSICIAN'S NAME (Type) Robert H. Levin, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried				23b. DATE THEREOF 2/24/62		23c. NAME OF CEMETERY OR CREMATORY Shapiro's Funeral Home Inc. 389-R. 2 Ave. N.W.		23d. LOCATION (City, town or county) Smithfield, N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Shapiro's Funeral Home Inc.				25a. REC'D BY REGISTRAR DATE FEB 27 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

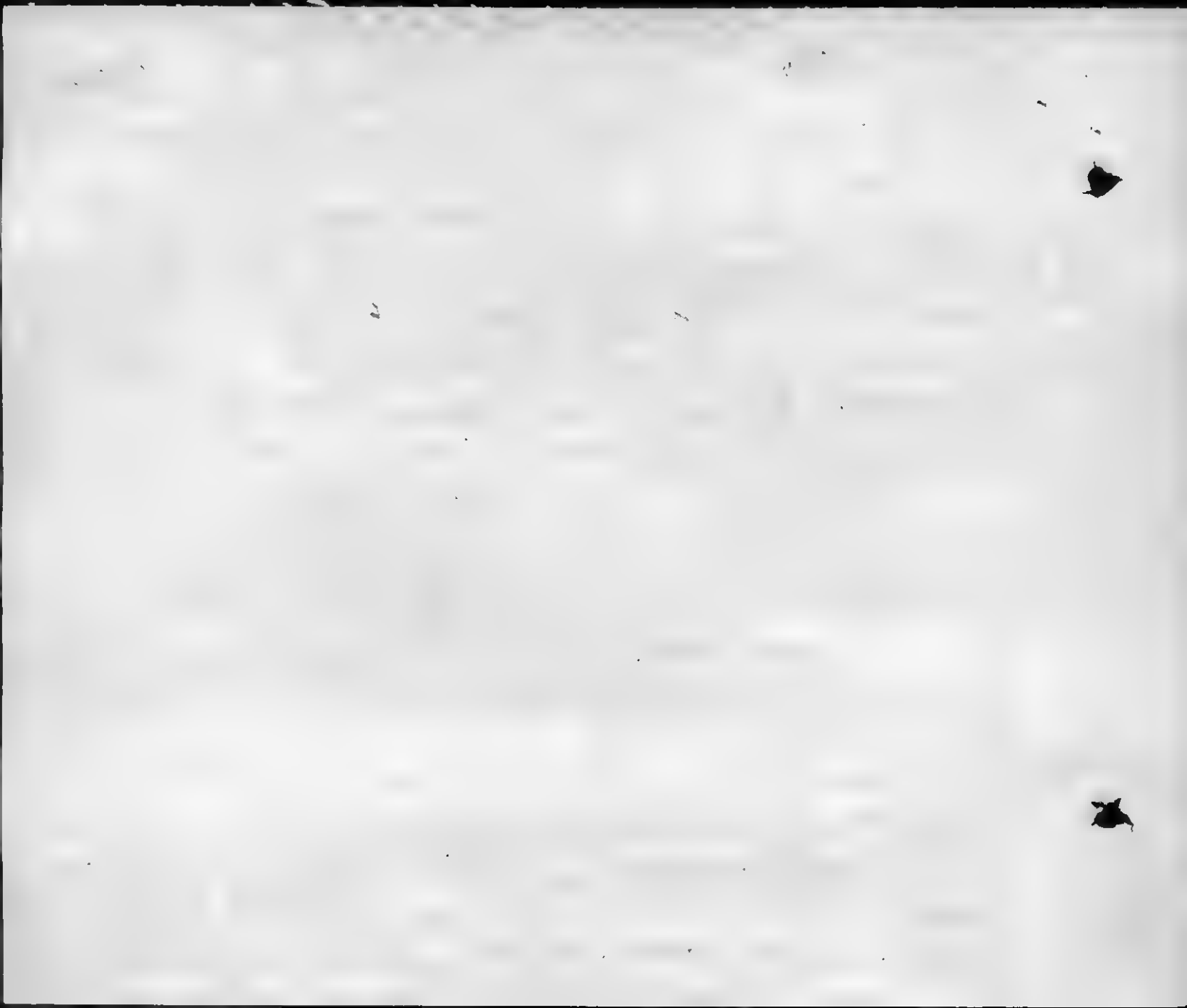
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>20 hrs</u>		d. STREET ADDRESS <u>11021 Dobbins Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia Mae Lee</u>	4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1962</u>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3 1892</u>
9. AGE (In years last birthday) <u>69</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond Butler Ferguson</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Tabor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-12-7316</u>	
17. INFORMANT <u>Carl E. Lee (son)</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCT</u> 4-2-2-2 DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which govern as to immediate cause (e), stating the underlying cause last. DUE TO (c) <u>DIABETES MELLITUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>2/14/62</u> 19 <u> </u> to <u>2/15/62</u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2/15/62</u> 19 <u> </u> , and that death occurred at <u>11:45 P</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry C. Scruggs</u> M.D.		22b. DATE SIGNED <u>2/15/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry C. Scruggs</u>		22d. ADDRESS <u>7720 Wisconsin Ave. Beth. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/19/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 21 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **NO FUNERAL DIRECTOR** Page 5 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				
c. LENGTH OF STAY IN 1b <u>7 yrs</u>					d. STREET ADDRESS <u>1602 Noyes Dr</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1602 Noyes Dr</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Mima W Lippe</u>					4. DATE OF DEATH <u>Feb 12 1962</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>3-9-1875</u>				
9. AGE (in years last birthday) <u>86 yrs</u>					10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>				
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Henry Wittland</u>					14. MOTHER'S MAIDEN NAME <u>Caroline Schmeier</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>NONE</u>				
17. INFORMANT <u>Edna Brown (sister)</u>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>h2c.1</u> DUE TO <u>Cornary occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> DUE TO <u> </u> (b) <u> </u> (c) <u> </u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u> </u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.) <u> </u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <u>Frank J. Broschant</u>					DATE SIGNED <u>Feb 12-62</u>				
ASSISTANT MEDICAL EXAMINER <u> </u>									
DEPUTY MEDICAL EXAMINER <u> </u>									
Address (Street, city, town, or county) <u> </u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>2/17/1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEM</u>		22d. LOCATION (City, town, or country) <u>QUINCY ILL</u> (State) <u> </u>		
23. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC SILVER SPRING, MD</u>					24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>				
Address <u> </u>					DATE <u>FEB 19 '62</u>				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please specify in this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY in lb 8 1/2 hours		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital,						d. STREET ADDRESS 8500 New Hampshire Ave.					
3. NAME OF DECEASED (Type or print) First Kathryne Middle Gant Last Lofland						4. DATE OF DEATH Month February Day 23 Year 19 62					
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 26, 1919		9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR: Months 23 Days 19 Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Palmer Morrow						14. MOTHER'S MAIDEN NAME Fay Gant					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT BOYD L. LOFLAND		Address SILVER SPRINGS, MD. 8500 NEW HAMPSHIRE AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema, acute DUE TO Conditions, if any, which gave rise to immediate cause (b) Pending toxicology studies DUE TO (c) Acute Salicylism											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported - drinking alcoholic beverages daily for unknown number of days. Started to have vertigo & tremor							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Silver Spring		20g. (County) Prince George's	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschert M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) FRANK J. BROSCHEART						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						22b. DATE THEREOF 2/27/62		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETARY		22d. LOCATION (City, town, or country) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR WARNER E. PUMPHREY						ADDRESS 434 GEORGIA AVE, SILVER SPRINGS MARYLAND		24a. REC'D BY REGISTRAR FEB 28 '62		24b. REGISTRAR'S SIGNATURE W. E. Pumphrey	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02097

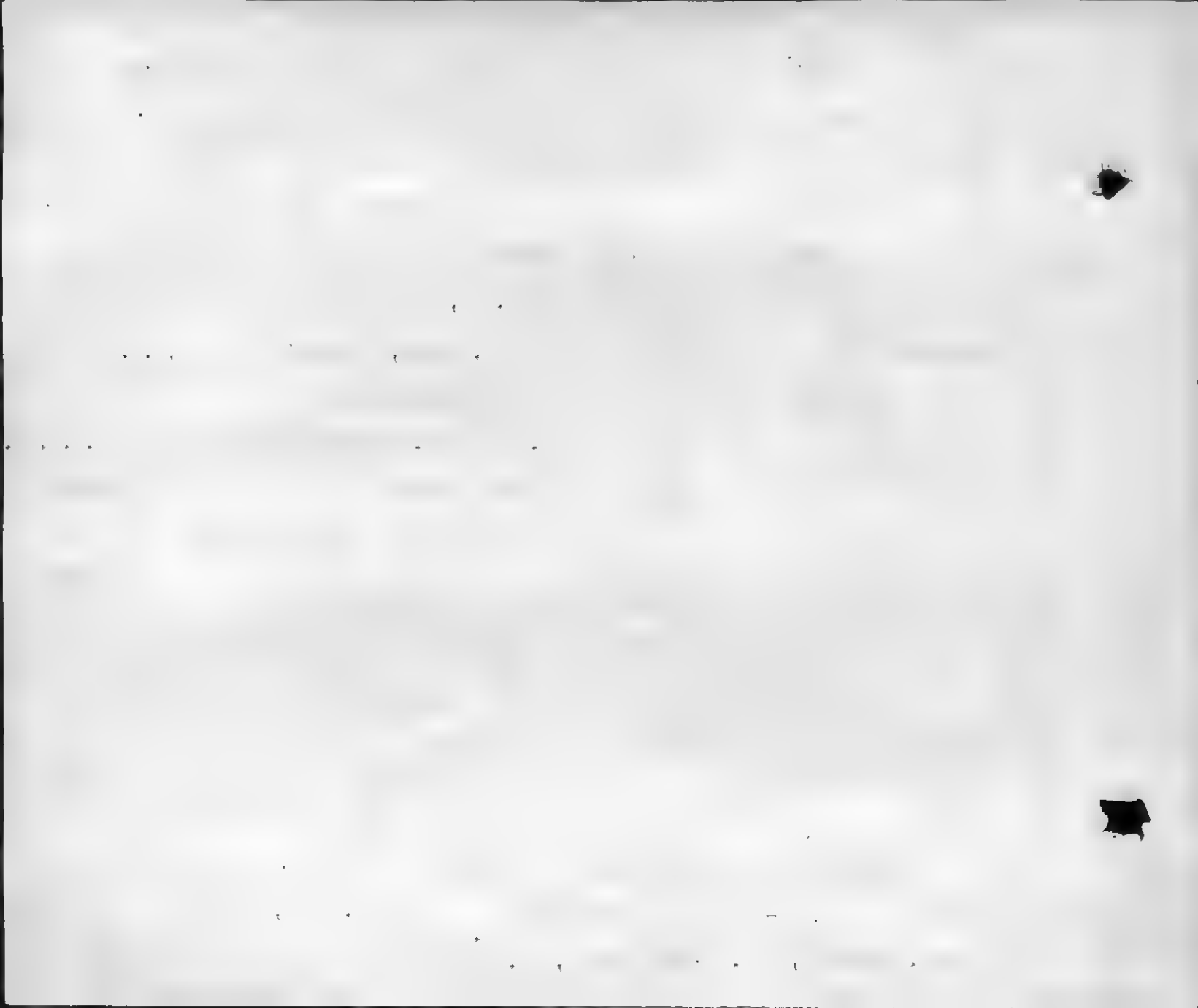
CERTIFICATE OF DEATH

02080

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN b. 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kensington Gardens Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) 37 Silver Spring d. STREET ADDRESS 2206 Prichard Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lillie (nmi) Lohman		4. DATE OF DEATH Month February Day 16 Year 1962		5. SEX female 6. COLOR OR RACE white			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 20, 1877		9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) St. Louis, Missouri			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frederick Reiffeiss		14. MOTHER'S MAIDEN NAME Catherine Geimer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Lillie L. Cleaver Address 2306 Blueridge Ave. S.S. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Embolus (b) Saddle Thrombus - Aorta & Iliac (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Fractured Right Femur 1/23/62 Pinned 1/29/62							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. TIME OF INJURY Month, Day, Year 2/14/62		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2/16/62			
21. I certify that (I) (this hospital) attended the deceased from 2/15/62 to 2/16/62, 1962, that (I) (we) last saw the deceased alive on 2/15/62, 1962, and that death occurred at 9:55 AM, from the causes and on the date stated above.							
22a. SIGNATURE Horace H. Custis Jr. M.D.		22b. DATE SIGNED 2/16/62		22c. PHYSICIAN'S NAME (Type) HORACE H. CUSTIS JR.			
22d. ADDRESS 1852 Columbia Rd NW WASH		23a. BURIAL, CREMATION, 23b. DATE THEREOF Burial 2-21-62					
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) St. Louis, Missouri (State) MO					
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE FEB 21 '62		25c. ADDRESS Georgia Ave. Silver Spring, Md.			

TO HOSPITAL: Page 1 of 2. TO FUNERAL: Page 2 of 2. TO REGISTRAR: Page 3 of 3. TO DIVISION OF STATISTICAL RESEARCH AND RECORDS: Page 4 of 4. TO DIVISION OF VITAL STATISTICS: Page 5 of 5. TO DIVISION OF PUBLIC HEALTH: Page 6 of 6. TO DIVISION OF LABOR RELATIONS: Page 7 of 7. TO DIVISION OF SOCIAL WELFARE: Page 8 of 8. TO DIVISION OF CHILD WELFARE: Page 9 of 9. TO DIVISION OF MENTAL HEALTH: Page 10 of 10. TO DIVISION OF PHYSICAL HEALTH: Page 11 of 11. TO DIVISION OF NURSING: Page 12 of 12. TO DIVISION OF MEDICAL RESEARCH: Page 13 of 13. TO DIVISION OF PHARMACEUTICALS: Page 14 of 14. TO DIVISION OF TOBACCO: Page 15 of 15. TO DIVISION OF ALCOHOL: Page 16 of 16. TO DIVISION OF DRUGS: Page 17 of 17. TO DIVISION OF MEDICAL DEVICES: Page 18 of 18. TO DIVISION OF MEDICAL SUPPLIES: Page 19 of 19. TO DIVISION OF MEDICAL SERVICES: Page 20 of 20. TO DIVISION OF MEDICAL EDUCATION: Page 21 of 21. TO DIVISION OF MEDICAL RESEARCH: Page 22 of 22. TO DIVISION OF MEDICAL RESEARCH: Page 23 of 23. TO DIVISION OF MEDICAL RESEARCH: Page 24 of 24. TO DIVISION OF MEDICAL RESEARCH: Page 25 of 25. TO DIVISION OF MEDICAL RESEARCH: Page 26 of 26. TO DIVISION OF MEDICAL RESEARCH: Page 27 of 27. TO DIVISION OF MEDICAL RESEARCH: Page 28 of 28. TO DIVISION OF MEDICAL RESEARCH: Page 29 of 29. TO DIVISION OF MEDICAL RESEARCH: Page 30 of 30. TO DIVISION OF MEDICAL RESEARCH: Page 31 of 31. TO DIVISION OF MEDICAL RESEARCH: Page 32 of 32. TO DIVISION OF MEDICAL RESEARCH: Page 33 of 33. TO DIVISION OF MEDICAL RESEARCH: Page 34 of 34. TO DIVISION OF MEDICAL RESEARCH: Page 35 of 35. TO DIVISION OF MEDICAL RESEARCH: Page 36 of 36. TO DIVISION OF MEDICAL RESEARCH: Page 37 of 37. TO DIVISION OF MEDICAL RESEARCH: Page 38 of 38. TO DIVISION OF MEDICAL RESEARCH: Page 39 of 39. TO DIVISION OF MEDICAL RESEARCH: Page 40 of 40. TO DIVISION OF MEDICAL RESEARCH: Page 41 of 41. TO DIVISION OF MEDICAL RESEARCH: Page 42 of 42. TO DIVISION OF MEDICAL RESEARCH: Page 43 of 43. TO DIVISION OF MEDICAL RESEARCH: Page 44 of 44. TO DIVISION OF MEDICAL RESEARCH: Page 45 of 45. TO DIVISION OF MEDICAL RESEARCH: Page 46 of 46. TO DIVISION OF MEDICAL RESEARCH: Page 47 of 47. TO DIVISION OF MEDICAL RESEARCH: Page 48 of 48. TO DIVISION OF MEDICAL RESEARCH: Page 49 of 49. TO DIVISION OF MEDICAL RESEARCH: Page 50 of 50. TO DIVISION OF MEDICAL RESEARCH: Page 51 of 51. TO DIVISION OF MEDICAL RESEARCH: Page 52 of 52. TO DIVISION OF MEDICAL RESEARCH: Page 53 of 53. TO DIVISION OF MEDICAL RESEARCH: Page 54 of 54. TO DIVISION OF MEDICAL RESEARCH: Page 55 of 55. TO DIVISION OF MEDICAL RESEARCH: Page 56 of 56. TO DIVISION OF MEDICAL RESEARCH: Page 57 of 57. TO DIVISION OF MEDICAL RESEARCH: Page 58 of 58. TO DIVISION OF MEDICAL RESEARCH: Page 59 of 59. TO DIVISION OF MEDICAL RESEARCH: Page 60 of 60. TO DIVISION OF MEDICAL RESEARCH: Page 61 of 61. TO DIVISION OF MEDICAL RESEARCH: Page 62 of 62. TO DIVISION OF MEDICAL RESEARCH: Page 63 of 63. TO DIVISION OF MEDICAL RESEARCH: Page 64 of 64. TO DIVISION OF MEDICAL RESEARCH: Page 65 of 65. TO DIVISION OF MEDICAL RESEARCH: Page 66 of 66. TO DIVISION OF MEDICAL RESEARCH: Page 67 of 67. TO DIVISION OF MEDICAL RESEARCH: Page 68 of 68. TO DIVISION OF MEDICAL RESEARCH: Page 69 of 69. TO DIVISION OF MEDICAL RESEARCH: Page 70 of 70. TO DIVISION OF MEDICAL RESEARCH: Page 71 of 71. TO DIVISION OF MEDICAL RESEARCH: Page 72 of 72. TO DIVISION OF MEDICAL RESEARCH: Page 73 of 73. TO DIVISION OF MEDICAL RESEARCH: Page 74 of 74. TO DIVISION OF MEDICAL RESEARCH: Page 75 of 75. TO DIVISION OF MEDICAL RESEARCH: Page 76 of 76. TO DIVISION OF MEDICAL RESEARCH: Page 77 of 77. TO DIVISION OF MEDICAL RESEARCH: Page 78 of 78. TO DIVISION OF MEDICAL RESEARCH: Page 79 of 79. TO DIVISION OF MEDICAL RESEARCH: Page 80 of 80. TO DIVISION OF MEDICAL RESEARCH: Page 81 of 81. TO DIVISION OF MEDICAL RESEARCH: Page 82 of 82. TO DIVISION OF MEDICAL RESEARCH: Page 83 of 83. TO DIVISION OF MEDICAL RESEARCH: Page 84 of 84. TO DIVISION OF MEDICAL RESEARCH: Page 85 of 85. TO DIVISION OF MEDICAL RESEARCH: Page 86 of 86. TO DIVISION OF MEDICAL RESEARCH: Page 87 of 87. TO DIVISION OF MEDICAL RESEARCH: Page 88 of 88. TO DIVISION OF MEDICAL RESEARCH: Page 89 of 89. TO DIVISION OF MEDICAL RESEARCH: Page 90 of 90. TO DIVISION OF MEDICAL RESEARCH: Page 91 of 91. TO DIVISION OF MEDICAL RESEARCH: Page 92 of 92. TO DIVISION OF MEDICAL RESEARCH: Page 93 of 93. TO DIVISION OF MEDICAL RESEARCH: Page 94 of 94. TO DIVISION OF MEDICAL RESEARCH: Page 95 of 95. TO DIVISION OF MEDICAL RESEARCH: Page 96 of 96. TO DIVISION OF MEDICAL RESEARCH: Page 97 of 97. TO DIVISION OF MEDICAL RESEARCH: Page 98 of 98. TO DIVISION OF MEDICAL RESEARCH: Page 99 of 99. TO DIVISION OF MEDICAL RESEARCH: Page 100 of 100.

Coroner notified and approved



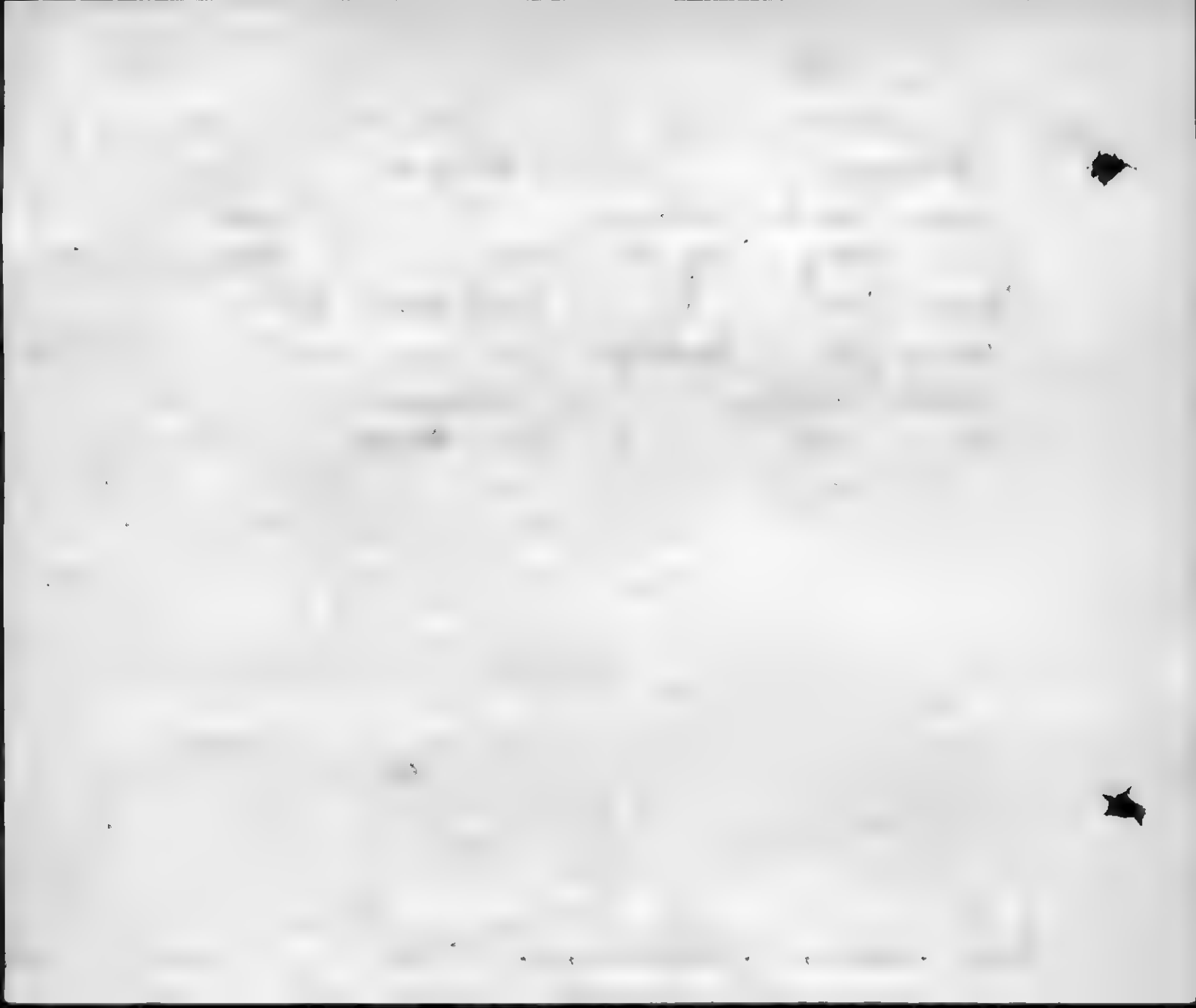
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

<div style="display: flex; justify-content: space-between;"> 02098 MARYLAND STATE DEPARTMENT OF HEALTH 02081 </div> <div style="text-align: center;"> DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 4 WEEKS c. LENGTH OF STAY IN 15				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Bethesda</u> d. STREET ADDRESS <u>9808 PARKWOOD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>9550 RIVER ROAD DRIVE</u>							
3. NAME OF DECEASED (Type or print) <u>MARY JACOBS</u> LOHRE First Middle Last				4. DATE OF DEATH <u>JANUARY 12 1962</u> Month Day Year							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 4 1875</u>		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.) <u>88</u> Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MADISON County, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Henry Judson W. JACOBS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN ALICE COPPAGE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. Charles E. Wilson</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE</u> (b) <u>CEREBRAL VASCULAR ACCIDENT</u> (c) <u>GEN'L ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTHYREXIA (1072)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>D.N.A.</u>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. CITY or town (County) (State) <u>Bethesda</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. CITY or town (County) (State) <u>Bethesda</u>	
21. I certify that (I) (this hospital) attended the deceased from... <u>16 JAN 1962</u> to <u>12 FEB 62</u> , that (I) (we) last saw the deceased alive on <u>2/11 1962</u> , and that death occurred <u>11:55 AM</u> , from the causes and on the date stated above.				22a. SIGNATURE <u>Charles J. Savarese, Jr.</u> M.D.				22b. ADDRESS <u>4890 BATTERY LANE</u> <u>BETHESDA MD</u>			
22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, JR.</u>				22d. ADDRESS <u>4890 BATTERY LANE</u> <u>BETHESDA MD</u>				22e. DATE <u>2/10/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Graham Cemetery</u>		23d. LOCATION (City, town or county) <u>Orange</u>		23e. LOCATION (City, town or county) <u>Virginia</u>		23f. LOCATION (City, town or county) <u>Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u>				24a. ADDRESS <u>301 Georgia Ave.</u>				24b. REC'D BY REGISTRAR <u>FEB 15 '62</u>			
24c. REGISTRAR'S SIGNATURE <u>Conning P. Jones</u>				24d. REGISTRAR'S SIGNATURE <u>Conning P. Jones</u>				24e. REGISTRAR'S SIGNATURE <u>Conning P. Jones</u>			

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FOR STATE
HEALTH DEPT.

NO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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02082
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>14 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington Hills</u> d. STREET ADDRESS <u>11803 Grandview Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Ellen NMN Lund</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 11, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>79</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. C.T.ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>MARIE UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Washington Sanatorium and Hospital records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pulmonary embolism</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause (a). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from bed in Hosp.</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-7-62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) <u>Takoma Park</u>	
20g. (County) <u>Montgomery</u>		20h. (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSBANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-7-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or country) <u>SUITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR <u>Real Funeral Home</u>		ADDRESS <u>4812 90th St. D.C.</u>	
24a. REC'D BY REGISTRAR <u>FEB 9 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Kraus</u>	



VS. AISME
5M 9/60

DATE FEB 7 '62

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

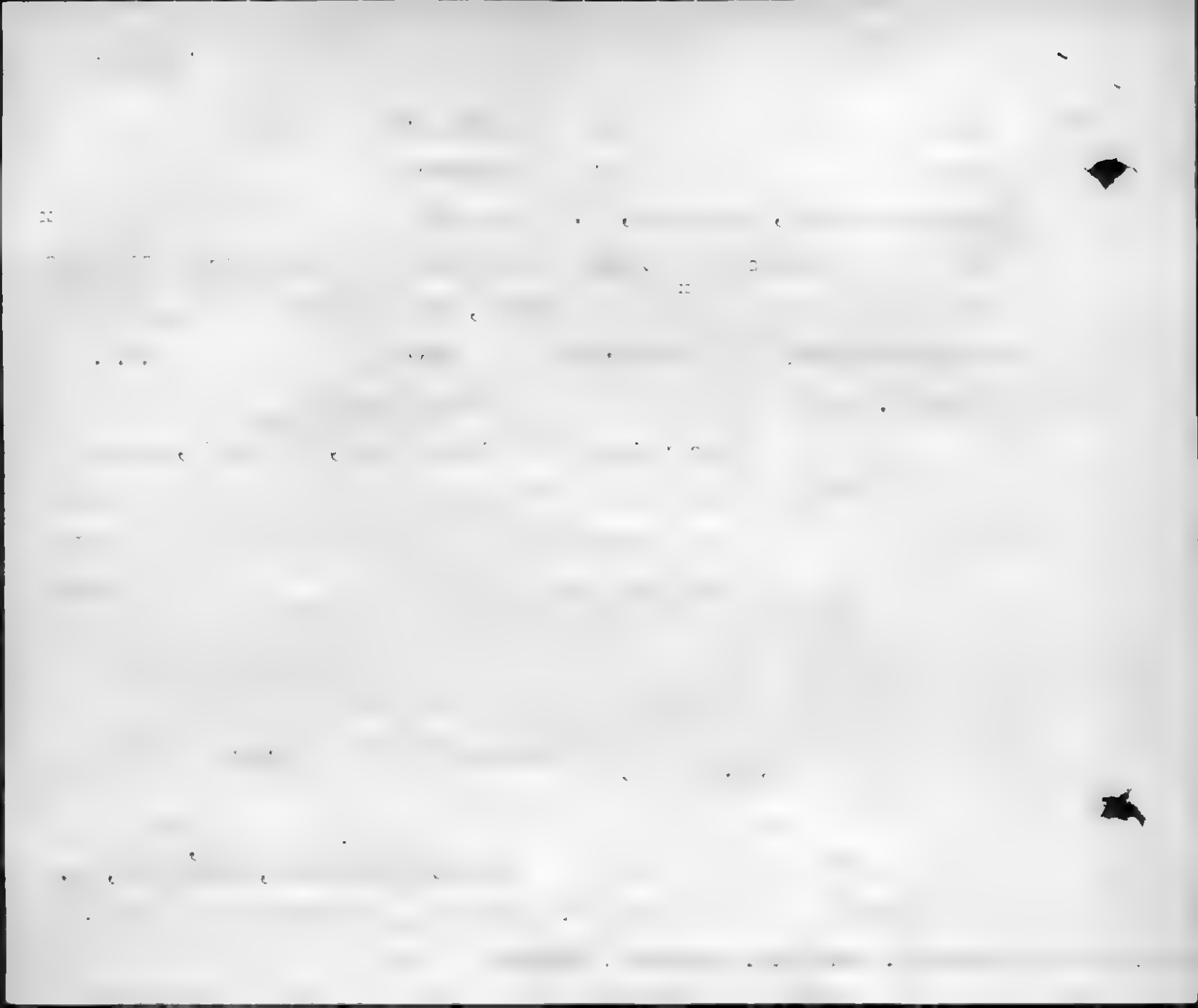
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02081

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY North Carolina	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 34 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Swannanoa	
3. NAME OF DECEASED (Type or print) Thomas Joseph Marett		4. DATE OF DEATH Month February Day 11 Year 19 62	
5. SEX Male		8. DATE OF BIRTH Last May 15, 1892	
6. COLOR OR RACE White		9. AGE (In years last birthday) 69 yrs.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer		11. BIRTHPLACE (County & State, or foreign country) Georgia	
10b. KIND OF BUSINESS OR INDUSTRY Engineering		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin I. Marett		14. MOTHER'S MAIDEN NAME Mary Lou Reese	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT The Medical Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Carcinoid DUE TO (c) Hypertensive Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 10 months 35 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (If (this hospital) attended the deceased from January 8, 19 62 to February 11, 19 62 that (I) (we) last saw the deceased alive on February 11, 19 62 , and that death occurred at 11:25 AM , from the causes and on the date stated above.			
22a. SIGNATURE Michael Field		22b. DATE SIGNED February 12, 1962	
22c. PHYSICIAN'S NAME (Type) Michael Field		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 2/13/62		23b. DATE THEREOF 2/13/62	
23c. NAME OF CEMETERY OR CREMATORY Black Mt. Cemetery		23d. LOCATION (City, town or county) (State) Black Mountain, N. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE FEB 14 '62	
25b. REGISTRAR'S SIGNATURE Carla L. P. Pumphrey			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02085

02102

1. PLACE OF DEATH
a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY in 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 15400 AVERY ROAD e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) SHENA LASHAY MARSHALL 4. DATE OF DEATH FEB 13 1962

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Nov. 14 1961 9. AGE (in years last birthday) 3 yrs. IF UNDER 1 YEAR: Months 3 Days 13 IF UNDER 24 HRS.: Hours 19 Min. 62

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND 11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME ERNEST MARSHALL 14. MOTHER'S MAIDEN NAME NANCY LARMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. NOTHER SAME AS ABOVE 17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
DUE TO (b) Upper respiratory infection
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Found cold in bed
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

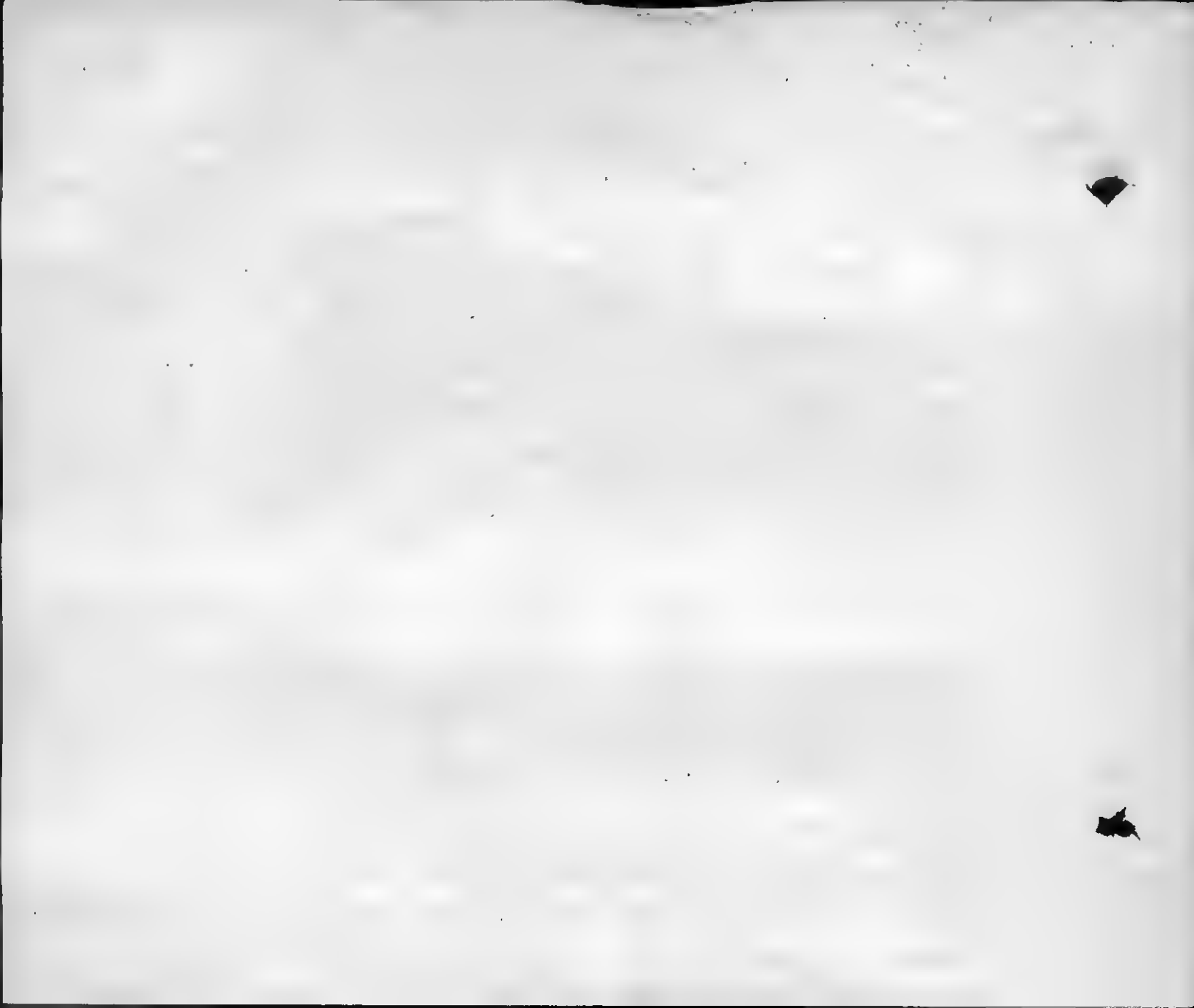
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Brochart CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☐ EXAMINER'S NAME (Type) FRANK J. BROCHART DEPUTY MED. CAL EXAMINER ☒ DATE SIGNED 2/13/62

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery 22c. LOCATION (City, town, or country) Gaithersburg, Maryland

23. FUNERAL DIRECTOR William C. Hilton ADDRESS Barneville 24a. REC'D BY REG. STRAR FEB 19 1962 24b. REGISTRAR'S SIGNATURE W. C. Hilton



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 206 Film 308 3-5-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02086

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda D.O.A.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE D.C. b. COUNTY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 3800 14th. Street, N.W.

3. NAME OF DECEASED (Type or print) First Middle Last
Marie Louise Martin

4. DATE OF DEATH Month Day Year
February 21, 19 62

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 6/22/04
9. AGE (in years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own home 11. BIRTHPLACE (State or foreign country) Paris, France 12. CITIZEN OF WHAT COUNTRY France

13. FATHER'S NAME Louis Chaume Chaume 14. MOTHER'S MAIDEN NAME Jeanne Martin Treny

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Denise Heilmann, 12104 Livingstone St. Address Wheaton, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Internal hemorrhage
704c DUE TO
Conditions, if any, which gave rise to immediate cause (b) Rupture of heart, liver & spleen
(a), stating the underlying cause lost. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Found lying at foot of basement stairs
20c. TIME OF INJURY Month. Day Year 12:29 p.m. 2-21 1962 20d. INJURY OCCURRED at work ☐ Not while at work ☒ 20e. PLACE OF INJURY Home ☐ factory, street, office bldg., etc. ☒ 12106 Livingston St. Wheaton, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL EXAMINER'S NAME (Type) Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 2-22-62

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-26-62 22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery 22d. LOCATION (City, town, or country) (State) Montgomery County Maryland

23. FUNERAL DIRECTOR Raymond Q. Ziska ADDRESS 8434 Georgia Ave 24a. REC'D BY REGISTRAR Warner E. Humphrey, Inc. Silver Spring, Md. 24b. REGISTRAR'S SIGNATURE Callie L. Hume DATE FEB 26 '62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02104

Item 9 Film G306 2/9/62 ink

02087

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b 33 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		d. STREET ADDRESS Rt. #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert C. Martin		4. DATE OF DEATH February 2, 1962		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/10/05		9. AGE (In years last birthday) \$750		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robt. MARTIN		14. MOTHER'S MAIDEN NAME Lucy BARKER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. Wife - Ethel Martin		17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute Myocardial Infarction (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 1-6, 1962 to 2-2, 1962, that (H) (we) last saw the deceased alive on 2-2, 1962, and that death occurred at 8:55 A.M. from the causes and on the date stated above. 22a. SIGNATURE P.P. Andrews 22b. PHYSICIAN'S NAME (Type) P.P. ANDREWS 22c. M.D. M.D. WASHINGTON 22d. ADDRESS D.C. 22e. DATE SIGNED 2-2-62 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/6/62 23c. NAME OF CEMETERY OR CREMATORY Lincoln Park, 23d. LOCATION (City, town or county) (State) Rockville, Md. 24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden 24b. ADDRESS Rockville, Md. 25a. REC'D BY REGISTRAR DATE FEB 7 '62 25b. REGISTRAR'S SIGNATURE Wm. J. Kline									

125



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

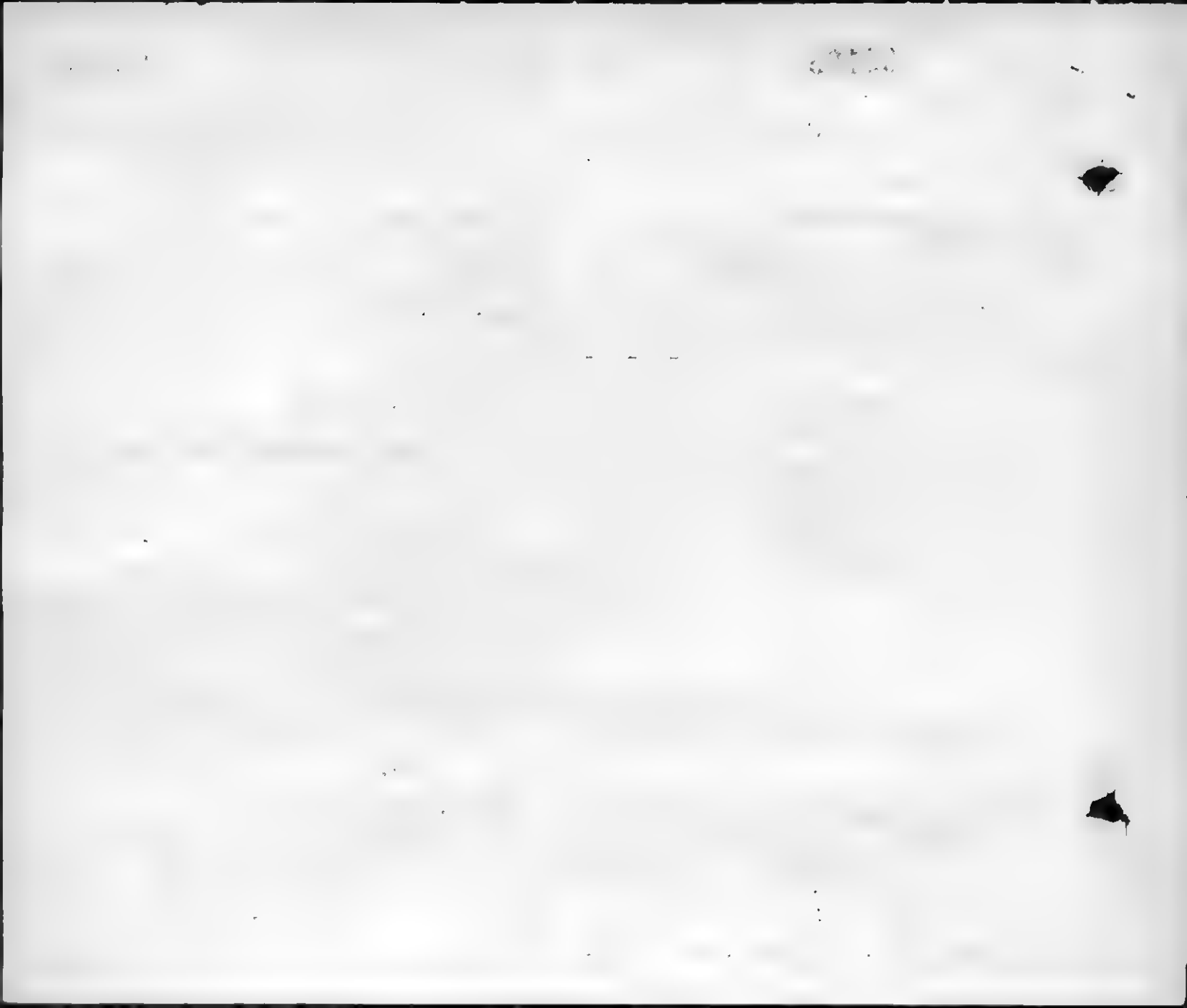
CERTIFICATE OF DEATH

02105

02088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>9835 Singleton Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Velma W Matthews</u>		4. DATE OF DEATH <u>Feb. 19 1962</u>		f. AGE (In years last birthday) <u>69 yrs.</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1892</u>	9. AGE (In years last birthday) <u>69 yrs.</u>
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Jonothan Wright</u>		14. MOTHER'S MAIDEN NAME <u>Laura A. Wilson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Mrs. William Olson-Daughter-same 2d</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>UREMIA</u> 1 <u>54X</u> DUE TO <u>URETERAL OBSTRUCTION</u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO <u>CARCINOMA OF RECTUM WITH METASTASES</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE VASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 DAYS</u> <u>14 DAYS</u> <u>2 YRS</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from <u>7/12 1961</u> to <u>2/19 1962</u> that (I) (we) last saw the deceased alive on <u>2/19 1962</u> and that death occurred at <u>3:00 PM</u> from the causes and on the date stated above.				
22a. SIGNATURE <u>John H. Tuohy</u>		22b. DATE SIGNED <u>2/19</u>	22c. PHYSICIAN'S NAME (Type) <u>JOHN H. TUOHY, M.D.</u>	
22d. ADDRESS <u>7720 WISCONSIN AVE BETHESDA 14, MD.</u>		22e. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>	23b. DATE THEREOF <u>2/20/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Lawn Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Wichita, Kansas</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 23 '62</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02106

CERTIFICATE OF DEATH

02089

Items 4 & 2, Form 5506 3/7/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 Chevy Chase</u>	
c. LENGTH OF STAY IN IB <u>7 1/2 days</u>		d. STREET ADDRESS <u>6642 Hillandale Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Otis</u> Middle <u>E</u> Last <u>Mays</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/10/75</u>
9. AGE (In years last birthday) <u>86</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	11. BIRTHPLACE (County & State or foreign country) <u>Oregon</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Benton Mays</u>		14. MOTHER'S M.A.DEN NAME <u>Elizabeth Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>son, Raymond C. Mayes, 3850 Tunlaw Rd. Wash. DC</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident.</u> 3:1X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia (Pt. had metastatic Carcinoma of glans penis.)</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 days.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off co bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>Feb 27, 1962</u> to <u>Feb 27, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 27, 1962</u> and that death occurred at <u>482</u> from the causes and on the date stated above.			
22. SIGNATURE <u>George A. Gray, Jr., M.D.</u>		22a. ADDRESS <u>4740 Chevy Chase Dr.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 1, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Murphy</u>		25. REC'D BY REGISTRAR <u>2 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>William L. Kenna</u>			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for our files.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02107

02090

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH STATE Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>10506 Powder Mill Rd</u>			
3. NAME OF (Type or print) First <u>Jane</u> Middle <u>Pariss</u> Last <u>McDowell</u>				4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>1962</u>			
5. SEX <u>7</u> <u>W</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-21-57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		9. AGE (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>1</u> IF UNDER 24 HRS: Hours <u>1</u> Min. <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Robert E McDowell</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Gill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Robert McDowell</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEMORRHAGIC PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ACUTE INTERSTITIAL VIRAL PNEUMONITIS</u> (c), stating the underlying cause last, DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>ACUTE CEREBRAL EDEMA</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20a. TIME OF INJURY Month <u>9</u> Day <u>4</u> Year <u>1962</u> Hour <u>11</u> a.m. <u>11</u> p.m.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20e. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bluschke</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BLUSCHKE</u>				DATE SIGNED <u>Feb 4 1962</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>2/4/62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Steele Creek</u>				22d. LOCATION (City, town, or country) (State) <u>Charlotte, N. C.</u>			
24a. REC'D BY REG. STRAR <u>Feb 6 '62</u>				24b. REGISTRAR'S SIGNATURE <u>John S. Hanna</u>			

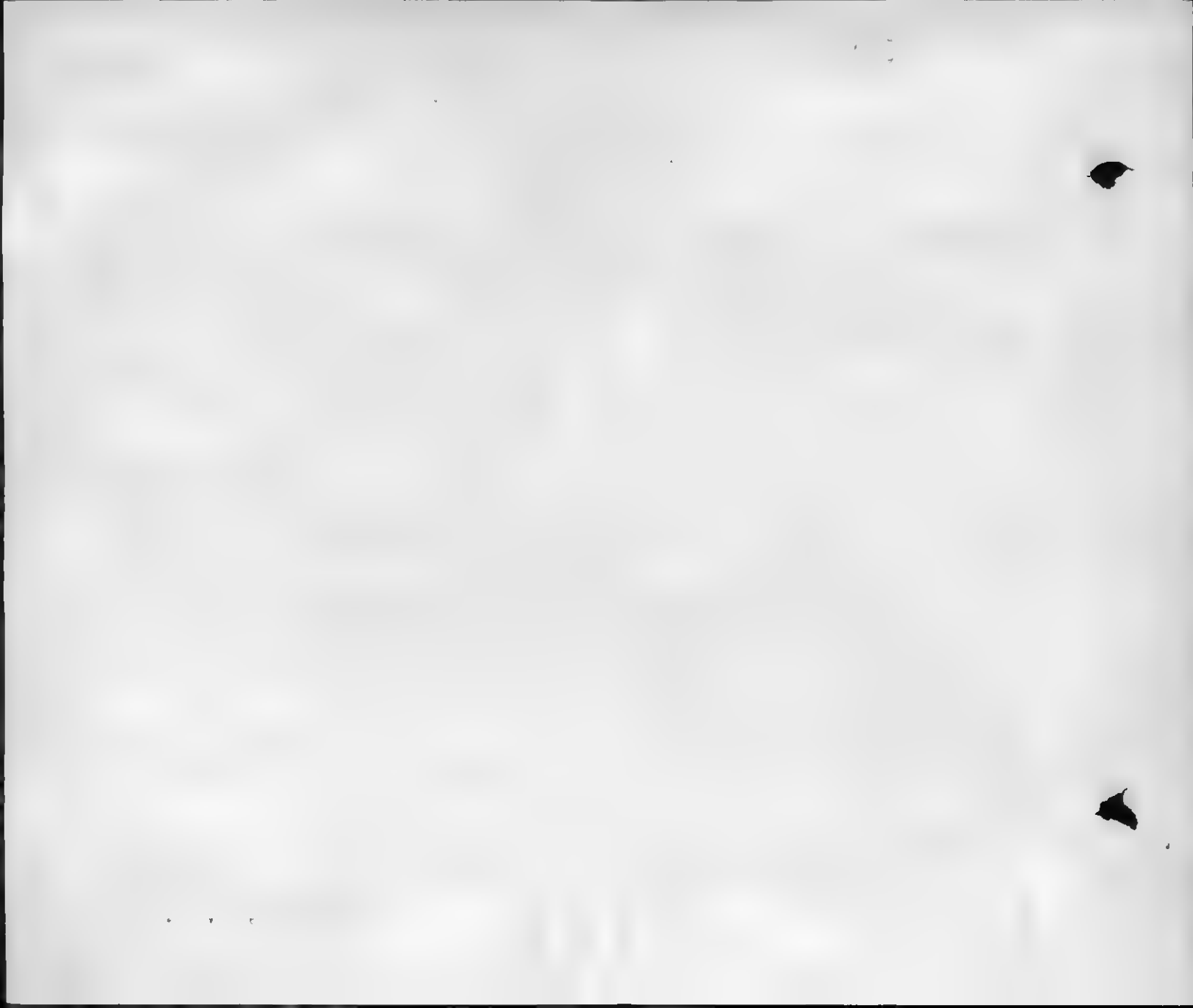
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MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

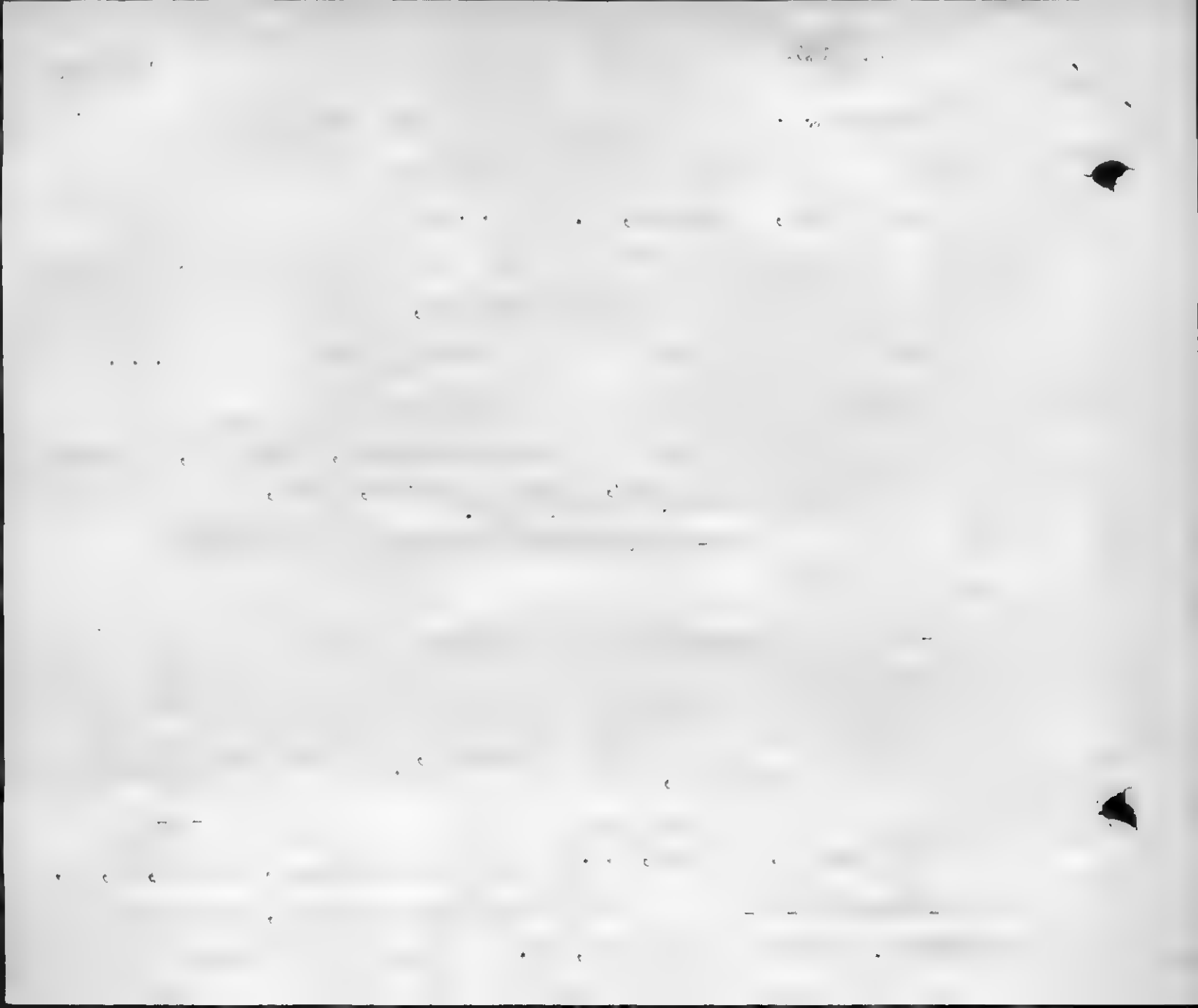
CERTIFICATE OF DEATH

02091

02108

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY (If in hospital, give street address) 82 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE North Carolina b. COUNTY Marion c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P.O. Box 809 d. STREET ADDRESS 708 S. 1st St.	
3. NAME OF DECEASED (Type or print) Frankie Jean McGee		4. DATE OF DEATH Month February Day 24 Year 19 62	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 17, 1953 9. AGE (In years last birthday) 8 yrs. 10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (County & State or foreign country) North Carolina 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John McGee 14. MOTHER'S MAIDEN NAME Rena Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO 16. SOCIAL SECURITY NO. None 17. INFORMANT The Medical Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Wilm's Tumor, Metastatic to liver, pelvis, subdiaphragmatic regions. DUE TO 15 Months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Post-operative absence of left kidney and spleen DUE TO 2-24-62 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year 19 62 Hour a.m. 7:15AM p.m. 7:15AM 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) The Clinical Center, National Institutes of Health, Bethesda, 14, Md. 20f. (City or town) Marion (County) North Carolina (State)	
21. I certify that (I) (this hospital) attended the deceased from December 4, 1962 to February 24, 1962, that (I) (we) last saw the deceased alive on February 24, 1962, and that death occurred at 7:15AM from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Henderson, M.D. 22c. PHYSICIAN'S NAME (Type) Edward S. Henderson, M.D.		22b. DATE SIGNED 2-24-62 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, 14, Md.	
23b. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 2-24-62 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery 23d. LOCATION (City, town or county) Marion, North Carolina (State)		24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY 25a. REC'D BY REGISTRAR DATE MAR 1 '62 25b. REGISTRAR'S SIGNATURE Earl S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, or by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

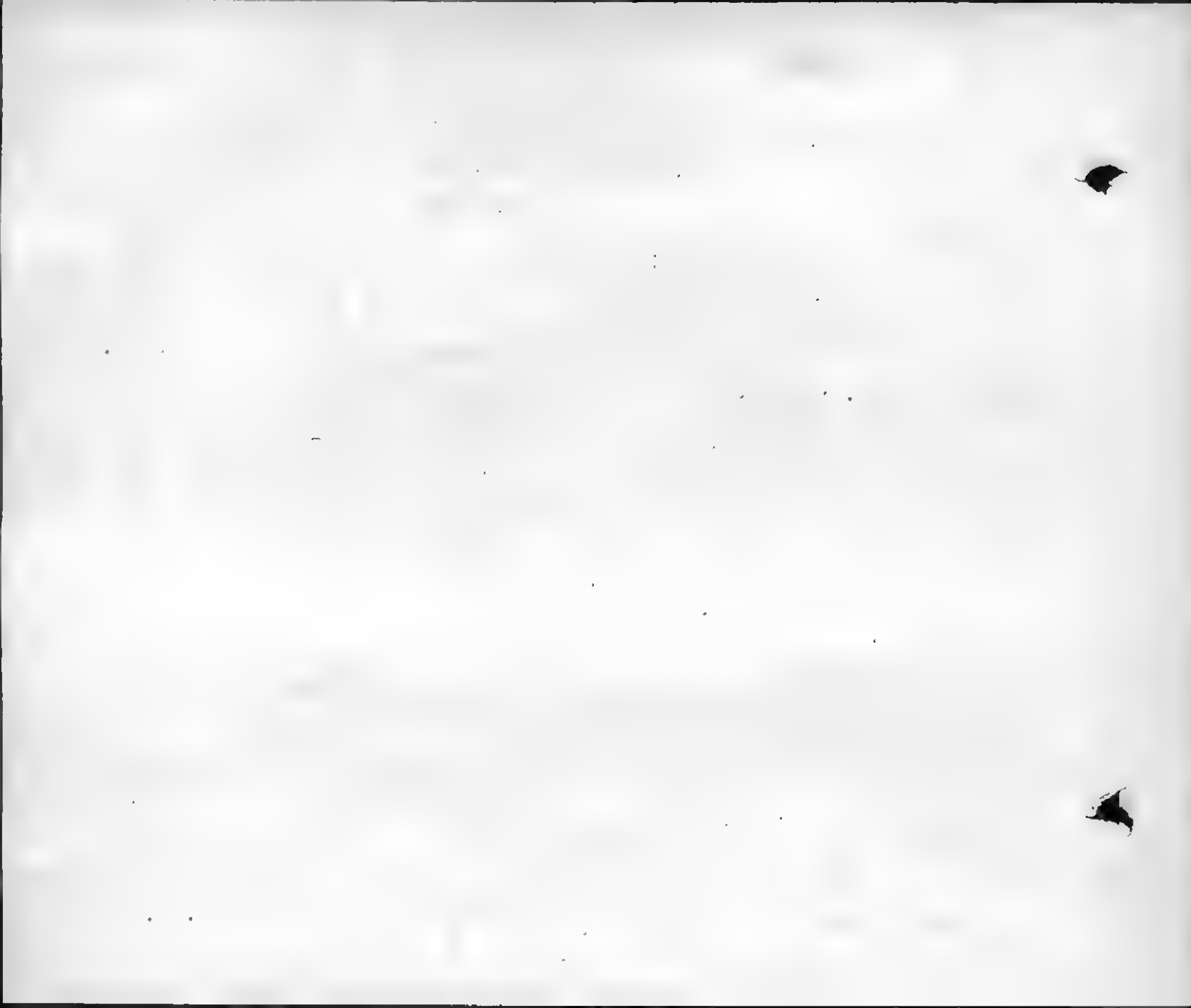
02109

02092

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>30 days</u>				d. STREET ADDRESS <u>2032 Belmont Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Veterans Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JEAN CURTICE</u> <u>McGoodwin</u>				4. DATE OF DEATH Month Day Year <u>Feb.</u> <u>22</u> <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 27, 1884</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles E. Curtice</u>			
14. MOTHER'S MAIDEN NAME <u>Jennie Heaton</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT Address <u>Preston McGoodwin-Hato Ray, Puerto Rico</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer from Adenocarcinoma (Reported & Surgically Done (1958), generalized metastasis Carcinoma of Rectum)</u> DUE TO (b) <u>3 yrs.</u> DUE TO (c) <u>3 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Denial, ordered no further medical treatment</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/5/62</u> to <u>2/22/62</u> , that (I) (we) last saw the deceased alive on <u>2/22/62</u> , and that death occurred at <u>6:55 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Sam Allen</u> <u>Kensington, Maryland</u> M.D.				22b. DATE SIGNED <u>2/22/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>SAM ALLEN</u>				22d. ADDRESS <u>10,407 Fairway Kensington, Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/26/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joe S. H. Hines Co. Wash, D.C.</u>				25a. REC'D BY REGISTRAR <u>FEB 26 '62</u>		25b. REGISTRAR'S SIGNATURE <u>W. S. Hines</u>	

M

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

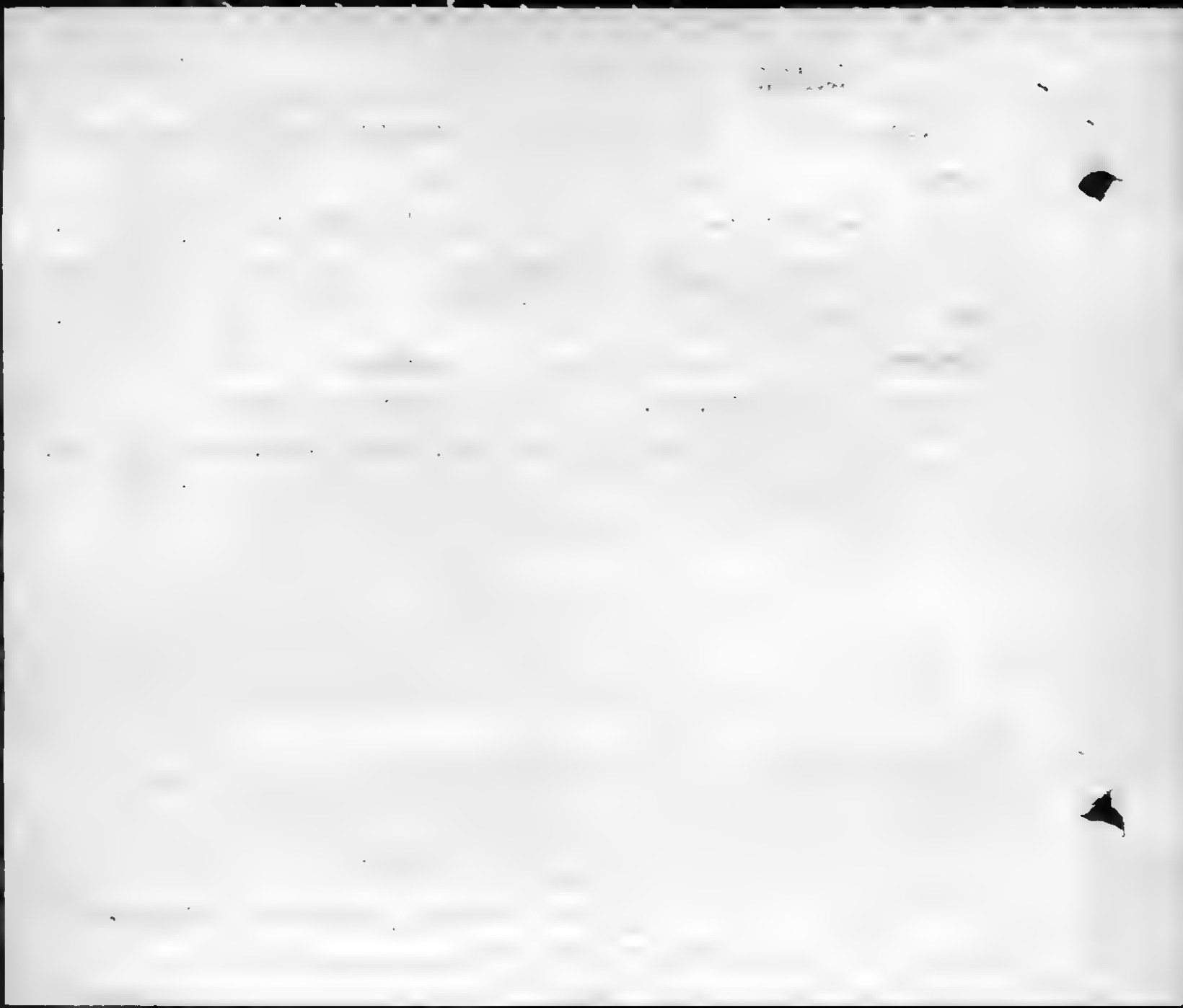
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02110

CERTIFICATE OF DEATH

02093

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b Bethesda d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7005 Clarendon Road		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 7005 Clarendon Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leslie David Measell		4. DATE OF DEATH Month Day Year Feb 12 19 62	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/1/86	
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 3 11	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Leslie D. Measell, Sr.		14. MOTHER'S MAIDEN NAME Fannie Gernand	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Calvin R. Measell-son, Kensington, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Congestive Heart Failure DUE TO (c) Coronary sclerosis and Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Diabetes mellitus and Angina pectoris INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 hours 20 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 25 , 19 61 , to Feb 12 , 19 62 , that (I) (we) last saw the deceased alive on Feb 12 , 19 62 , and that death occurred at 1:45 M, from the causes and on the date stated above.			
22a. SIGNATURE R. Stephen Hulbert M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) R. Stephen Hulbert 22d. ADDRESS 3000 Dent Place NW 22b. DATE SIGNED Feb 12/1962			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 2/15/62 23b. DATE THEREOF 2/15/62 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 23d. LOCATION (City, town or county) (State) Portsmouth, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland ADDRESS Bethesda, Maryland 25a. REC'D BY REGISTRAR FEB 14 '62 25b. REGISTRAR'S SIGNATURE James S. P. Jones			



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FOR STATE
HEALTH DEPT.

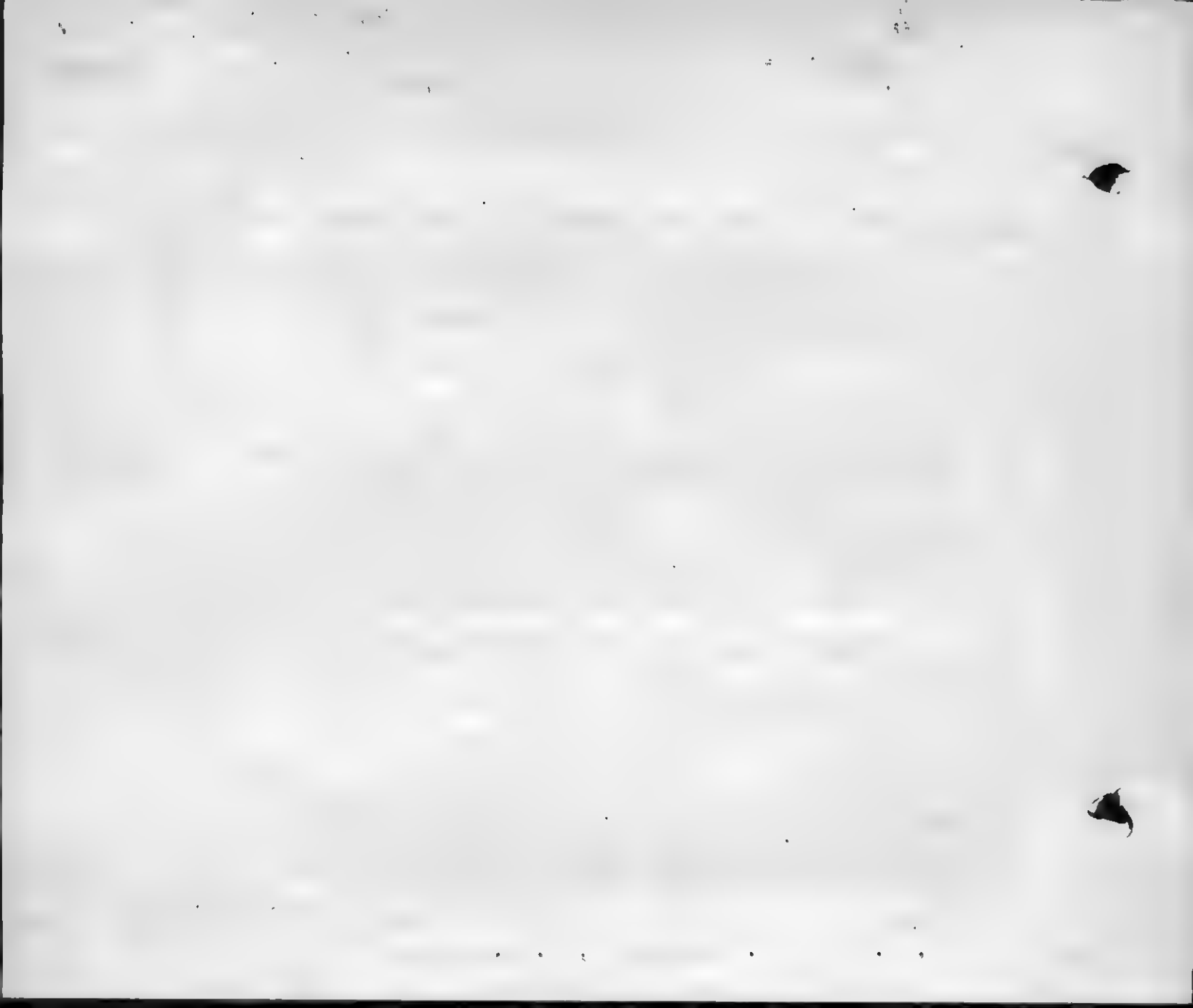
MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02091

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY in 1b <u>7 wks</u>		d. STREET ADDRESS <u>1474 Columbia Rd N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marie Rachel Meeker</u>		4. DATE OF DEATH <u>Feb 8 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-1881</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>	
13. FATHER'S NAME <u>Wm W. Whelock</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Ann Roche</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Nursing Home Record</u>		Address <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>The S. H. Hines Co. Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>Feb 13 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>L. J. Hines</u>		DATE <u>FEB 13 '62</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

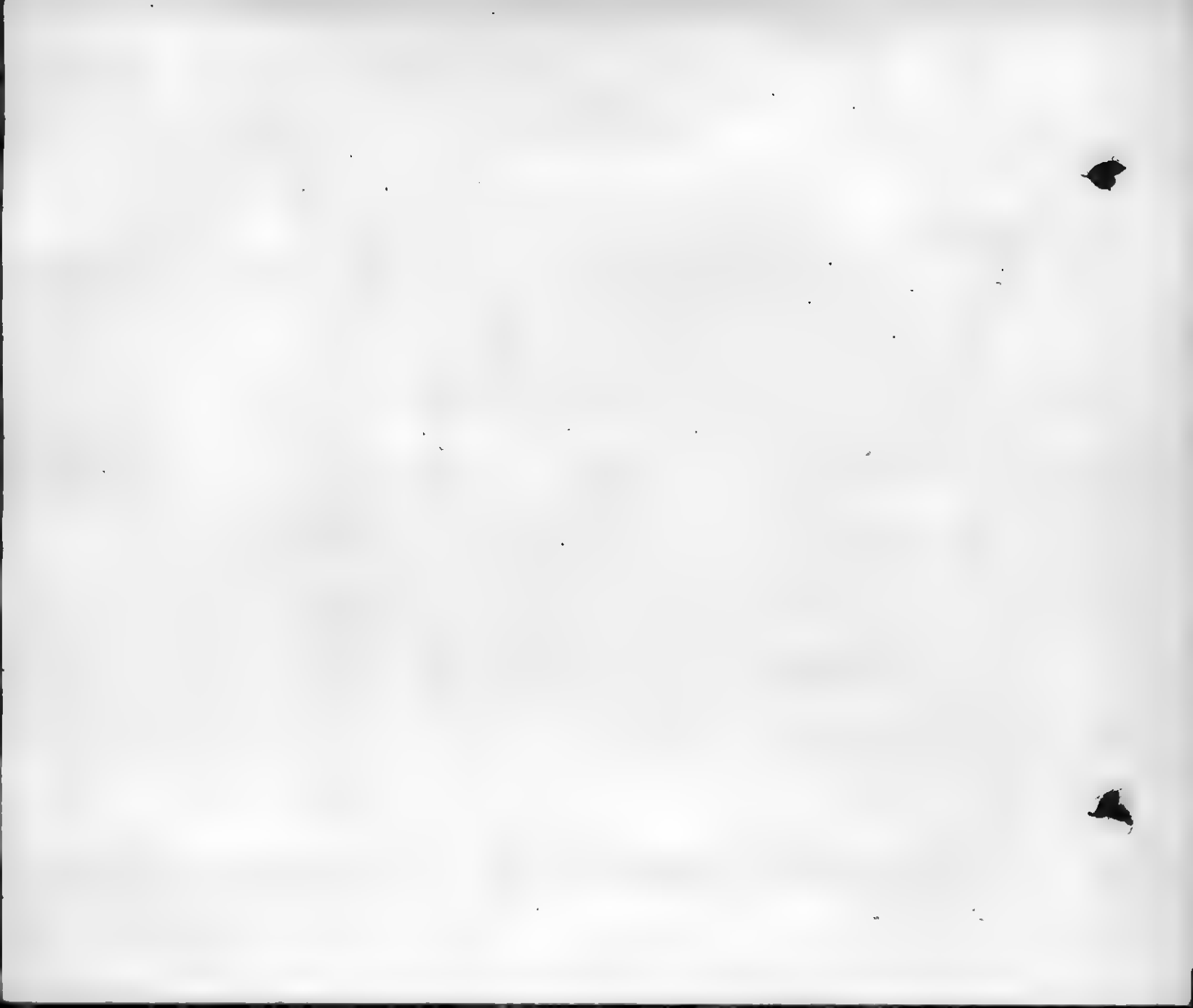


02112

CERTIFICATE OF DEATH

Reg. Dist. No. 02095

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENNINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE VFW, KENNINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>4312-BLENROSE ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>WILHELMINA</u> Middle <u>O.</u> Last <u>MEITZLER</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 2, 1870</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STEPHEN HELLMUTH</u>		14. MOTHER'S MAIDEN NAME <u>PAULINE BUEHL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>PAULINE M. MEITZLER</u> Address <u>SEE 2D</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CONGESTIVE HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERIO-SCLEROSIS</u> DUE TO <u>2 yrs</u> (c) <u>GENERALIZED ARTEROSCLEROSIS</u> DUE TO <u>15 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>aug 15</u> , 19 <u>40</u> , to <u>FEB 19</u> , 19 <u>62</u> that I last saw the deceased alive on <u>FEB 16</u> , 19 <u>62</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas W Harnsberger</u> M.D. <u>4201 NEW HAMPSHIRE AVE NW</u>		DATE SIGNED <u>2/19/62</u>	
PHYSICIAN'S NAME (Type) <u>CHAS. W. HARNSEBERGER</u>		<u>WASHINGTON D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB 22, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR Hill CEMETRY</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Therese Hannon</u> ADDRESS <u>4148 WISC. AVE NW</u>		24a. REC'D BY REGISTRAR <u>C</u> DATE <u>FEB 23 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>18. Lane</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

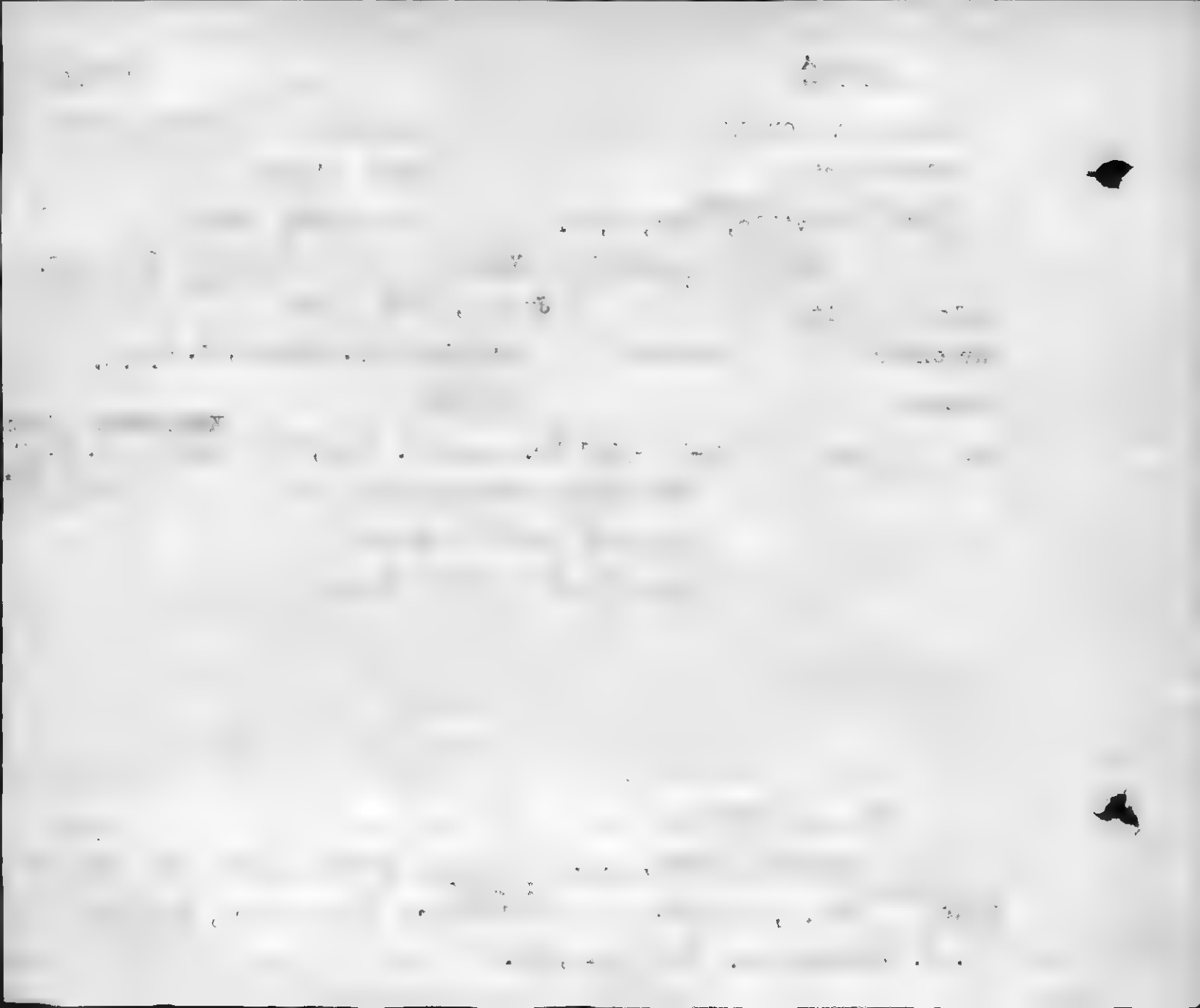
02113

02096

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY in 1b Belmont Nursing Home d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 17220 Colesville, Road, SS, Md.		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland Prince Georges b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Rainier d. STREET ADDRESS 3201 Arundel Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BYRD ALBERT MOORE 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH June 6, 1878 9. AGE (In years last birthday) 83 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 11. BIRTHPLACE (County & State, or foreign country) Franklin Cty. Henrico, Va. U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 23-118-5371 17. INFORMANT Mr. Aleph H. Wood, 3812 Kearney Rd. Manor 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis (b) Cerebral atherosclerosis (c) Generalized atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 days 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 12/1/1962 Hour a.m. 12/1 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12/1/1962 20f. (City or town) 3/4/1962 20g. (County) 12/1/1962 20h. (State) 12/1/1962		21. I certify that (I) (this hospital) attended the deceased from 12/1/1962 to 3/4/1962 that (I) (we) last saw the deceased alive on 12/1/1962 and that death occurred at 6 P.M. from the causes and on the date stated above. 22a. SIGNATURE Donald Nelson 22b. DATE SIGNED 2/6/62 22c. PHYSICIAN'S NAME (Type) DONALD NELSON, M.D. 22d. ADDRESS 10620 Georgia Ave., Silver Spring, Md. 23a. BURIAL 23b. DATE THEREOF 23c. NAME OF CEMETERY 23d. LOCATION (City, town or county) (State) Burial Feb. 9, 1962 Fort Lincoln Cemetery Bladensburg, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO. Riverdale, Md. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE FEB 9 '62	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

1
02114
MONTGOMERY
02097
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Wash., D.C. b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 11 months	
d. NAME OF HOSPITAL (If not hospital, give street address) OR INSTITUTION 11901 Georgia Avenue Wheaton Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X	
f. STREET ADDRESS 4301 Mass. Ave. N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isabelle Middle Morache Last Morache		4. DATE OF DEATH Month Feb. Day 11 Year 1962	
5. SEX Female 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct. 2, 1871		9. AGE, in years last birthday 90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alfred Archambault		14. MOTHER'S MAIDEN NAME Emma Dessereau	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. no	
17. INFORMANT Daughter Address Mrs Frank Stemple 4301 Mass. Ave N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 4-20-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombo-Phlebitis 7 Myocardial Vessel Cases		INTERVAL BETWEEN ONSET AND DEATH 3 days 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 4, 1962 to Feb. 11, 1962 that (I) (we) last saw the deceased alive on 2/10 19 62 and that death occurred at 8 AM from the causes and on the date stated above			
22a. SIGNATURE Samuel Dessoff		22b. ADDRESS 1302 18th St N.W. Wash. D.C.	
22c. PHYSICIAN'S NAME (Type) SAMUEL DESOFF		22d. ADDRESS 1302 18th St N.W. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/14/62	
23c. NAME OF CEMETERY OR CREMATORY St. Catherine's Cemetery		23d. LOCATION (City, town, or county) (State) Moscow Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE The H.H. Hines Co.		25a. REC'D BY REGISTRAR 290114th (J. AW)	
25b. REGISTRAR'S SIGNATURE 290114th (J. AW)		25c. DATE Feb 13 '62	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with this State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

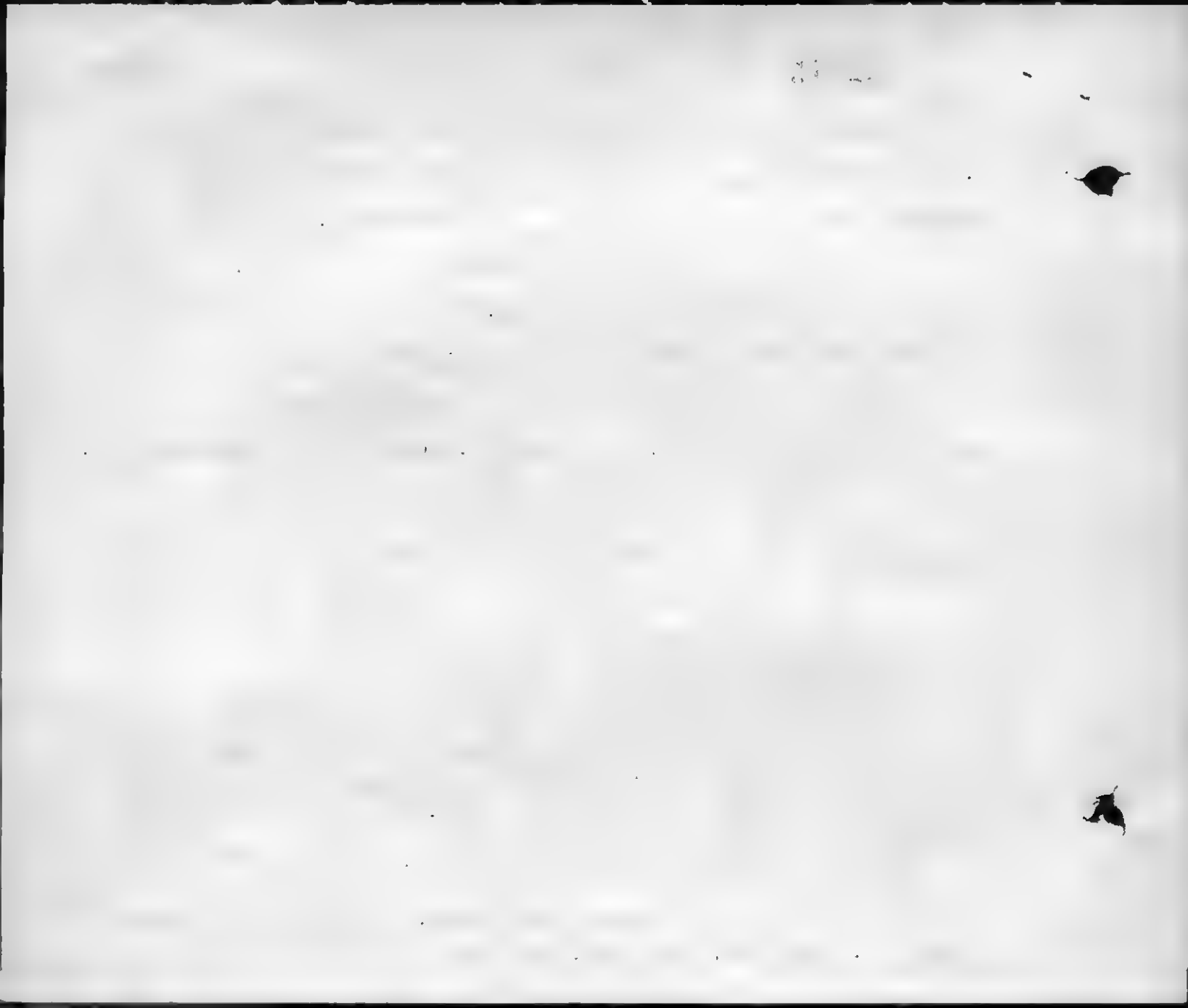
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02115

CERTIFICATE OF DEATH

02098

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac (rural)</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac Manor</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>8609 Burdette Road</u> d. STREET ADDRESS <u>Bethesda, Maryland</u>	
3. NAME OF DECEASED (Type or print) <u>David L Morgal</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 31, 1874</u> 9. AGE (in years, if UNDER 1 YEAR; if UNDER 24 HRS last birthday) <u>87</u> yrs. <u>1</u> month <u>16</u> days <u>16</u> hours <u>62</u> min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner-Golf Club Gardening</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Morgal</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Ralph L. Morgal-Son-Cabin John, Md.</u>		14. MOTHER'S MAIDEN NAME <u>Martha (Unknown)</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respirator Failure</u> DUE TO (b) <u>Bronchopneumonia</u> (c) <u>General Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis Heart</u>	
20c. TIME OF INJURY Month, Day, Year <u>Feb 17 1962</u> Hour a.m. <u>19</u> p.m.		21. I certify that (I) (this hospital) attended the deceased from Jan 1962 to Feb 1962, that (I) (we) last saw the deceased alive on Feb 17 1962, and that death occurred at 8 P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>W. H. Killay</u> 22c. PHYSICIAN'S NAME (Type) <u>W. H. Killay</u>		22b. DATE SIGNED <u>Feb 23 1962</u> 22d. ADDRESS <u>6218 Wisconsin Ave Bethesda</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/21/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Potomac Church Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Potomac, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 23 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Chas E. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02099

1. PLACE OF DEATH 02116		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)	
a. COUNTY Montgomery	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	a. STATE Maryland	b. COUNTY Montgomery
c. LENGTH OF STAY IN It 10		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 25 Wall St., R	
3. NAME OF DECEASED (Type or print) L. CURTIS		4. DATE OF DEATH February 12, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/10/93	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank L. Mortimer		14. MOTHER'S MAIDEN NAME Catherine J. Moorehead	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-03-1644	
17. INFORMANT wife, Sara A. Mortimer		Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Peritonitis 57.8X DUE TO Perforation of Cecum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 2 wks (c) 2 wks		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-8 19 62 to 2-12 19 62 ; that (I) (we) last saw the deceased alive on 2-10 19 62 and that death occurred at 12:45 from the causes and on the date stated above.			
22a. SIGNATURE W. G. Hall		22b. DATE SIGNED 2-12-62	
22c. PHYSICIAN'S NAME (Type) Wm. G. Hall		22d. ADDRESS 615 W. Montg. Ave., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/14/62	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Sipon Wheeler		25a. REC'D BY REGISTRAR DATE FEB 13 '62	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	



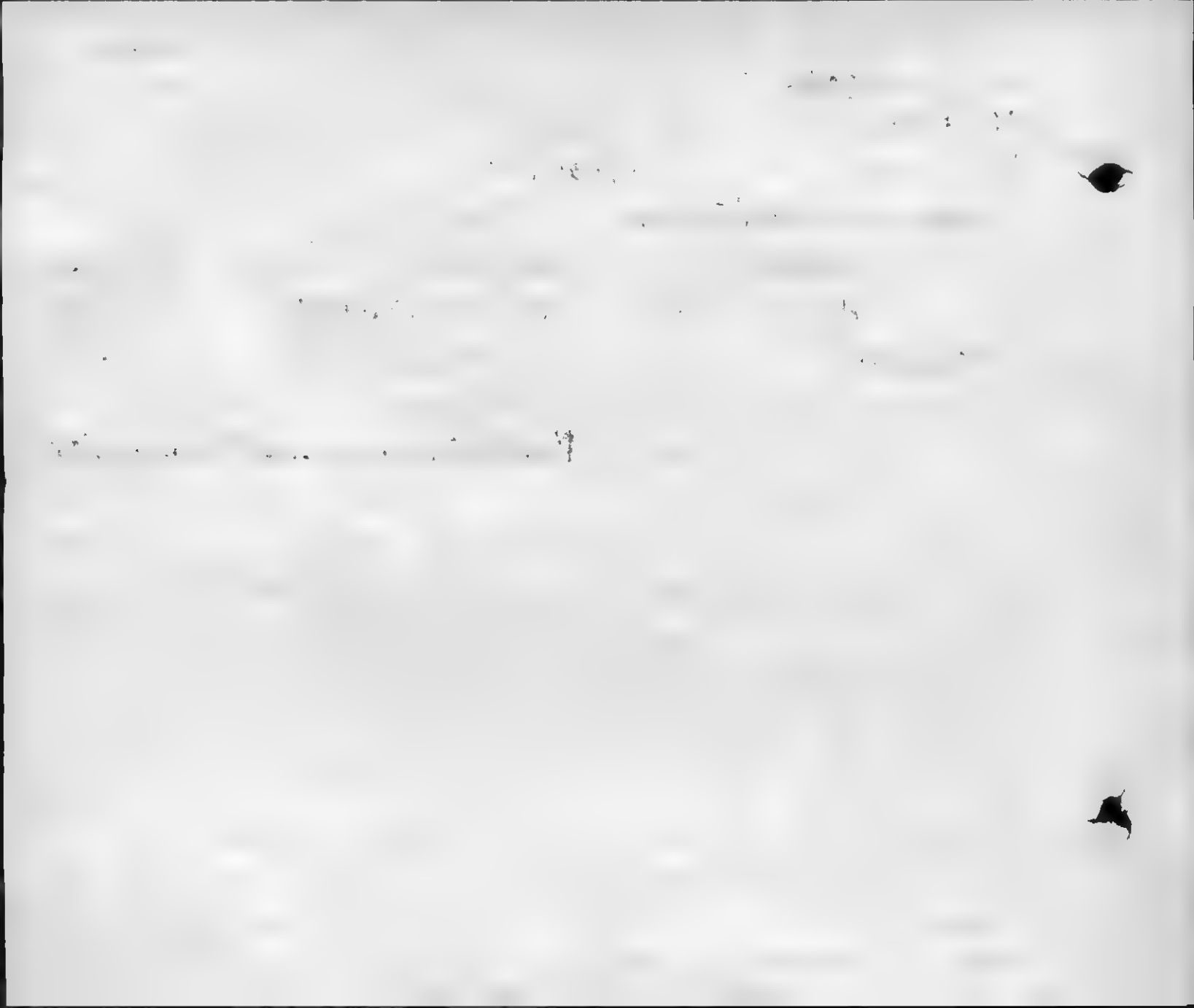
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VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

021100

1. PLACE OF DEATH 02117
a. COUNTY **Montgomery**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Kensington**
c. LENGTH OF STAY IN 1b **6-20-59/2/3/62**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Carroll Hall Sanitarium**
2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE **DC**
b. COUNTY **Washington**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Washington DC 412**
d. STREET ADDRESS **3683 Ala. Ave. SE**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3. NAME OF DECEASED (Type or print) **Lizette V. Munson**
4. DATE OF DEATH **Feb. 3 1962**
5. SEX **F**
6. COLOR OR RACE **W**
7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH **Nov. 30, 1864**
8. WIDOWED ☒ DIVORCED ☐
9. AGE (In years last birthday) **97**
10. IF UNDER 1 YEAR Months Days Hours Min.
11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife**
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) **New York City**
12. CITIZEN OF WHAT COUNTRY? **U.S.A.**
13. FATHER'S NAME **Francis Adams**
14. MOTHER'S MAIDEN NAME **Mary**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT **Mr. William Peck, 3683 Ala. Ave. D.C.**
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **HYPERTENSIVE HEART DISEASE**
DUE TO **CEREBRAL HEMORRHAGE**
DUE TO **GENERALIZED ARTERIOSCLEROSIS**
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
SENILITY
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19**
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from **JUNE 20, 1959** to **FEB. 3, 1962** that (I) (we) last saw the deceased alive on **FEB. 3, 1962**, and that death occurred at **6:00 PM**, from the causes and on the date stated above.
22a. SIGNATURE **Henry Louden**
22b. DATE SIGNED **2/3/62**
22c. PHYSICIAN'S NAME (Type) **HENRY LOUDEN**
22d. ADDRESS **5206 NORWAY DR. CHEVY CHASE, MD**
22e. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22f. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**
23b. DATE THEREOF **Feb-5-62**
23c. NAME OF CEMETERY OR CREMATORY **Cedar Hill Cemetery**
23d. LOCATION (City, town or county) (State) **Sanford and**
24. FUNERAL DIRECTOR'S SIGNATURE **Sammons Bros 1661-9d Hape Rd**
24b. ADDRESS
25. REC'D BY REGISTRAR **DATE FEB 5 '62**
25b. REGISTRAR'S SIGNATURE **Carroll**



CERTIFICATE OF DEATH

Reg. Dist. 02101

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 7 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1909 GLENALLAN AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Aguus Last Murphy		4. DATE OF DEATH Month Feb Day 10 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-76
9. AGE (In years lost birthday) 85 yrs		10. IF UNDER 1 YEAR Months 3 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS. Months 3 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY PENNA.	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PHILIP GRAHAM		14. MOTHER'S MAIDEN NAME MARY JANE McDONALD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO PAUL W. MURPHY	
17. INFORMANT Same as #1		Address Same as #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute congestive heart failure DUE TO (b) arteriosclerotic heart disease DUE TO (c) 10 yrs Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 12, 1962 to Feb 10, 1962 that I last saw the deceased alive on Feb 10, 1962 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE H. F. Kreuzburg		M.D. 7852 16 St NW Wash DC	
PHYSICIAN'S NAME (Type) H. F. Kreuzburg			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-13-62	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS WASH. D.C.		24a. REC'D BY REGISTRAR DATE 13 '62	24b. REGISTRAR'S SIGNATURE S. Thana

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1
MONTGOMERY
96
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02119- Item 12 Film G308 3/2/62
02102
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. (Zone 18)</u> c. LENGTH OF STAY IN 1b <u>30 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2316-14th St. N.E. 4</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. (Zone 18)</u> d. STREET ADDRESS <u>2316-14th St. N.E. 4</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK NICASTRI</u> First Middle Last 4. DATE OF DEATH <u>2-15-1962</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>9/16, 1886</u> 9. AGE (In years, if under 1 year, if under 24 hrs.) <u>75</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Plastering</u> 11. BIRTHPLACE (Country & State or foreign country) <u>Roma, Italy</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Dominic J. Nicastri</u> Address <u>above</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Probable recurrent myocardial infarction</u> (e), stating the underlying cause last. (c) <u>Unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>None</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, notify medical examiner.) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year <u>2/15/62</u> Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Washington, D.C. (Montgomery County) D.C.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/15/62</u> to <u>2/15/62</u> and that (I) (we) last saw the deceased alive on <u>2/15/62</u> and that death occurred <u>at home</u> from the causes and on the date stated above.		22a. SIGNATURE <u>John C. Nicastri, Jr.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2/15/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN C. NICASTRI, JR.</u>		23a. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 23b. DATE THEREOF <u>2/19/62</u> 23c. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u> 25a. REC'D BY REGISTRAR <u>Inc.</u> 25b. REGISTRAR'S SIGNATURE <u>Inc.</u> DATE <u>FEB 20 '62</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. Page 4 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

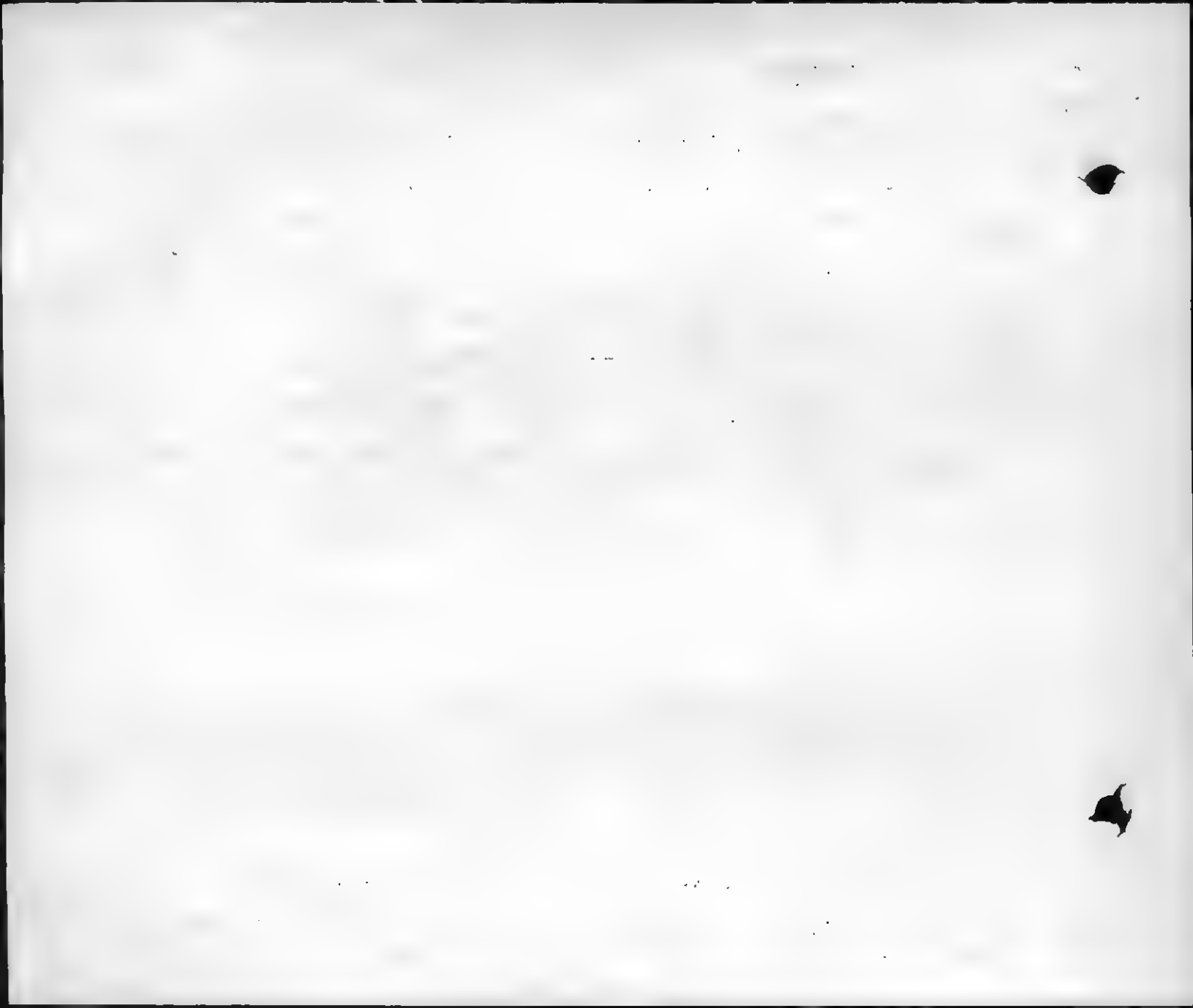
VR AIS 1
ISM 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02120

02103

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>310 Edmonston Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>310 Edmonston Drive</u>	
3. NAME OF DECEASED (Type or print) <u>BERTHA</u> First <u>J</u> Middle <u>Ni FONG</u> Last 4. DATE OF DEATH <u>Feb. 25</u> 19 <u>62</u> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 20, 1889</u> 9. AGE (In years last birthday) <u>72</u> yrs. 10. IF UNDER 1 YEAR Months <u>9</u> Days <u>5</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 13. FATHER'S NAME <u>James M. Jarvis</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Francis Straford-daughter-same 2d</u> Address <u></u>		14. MOTHER'S MAIDEN NAME <u>Agustia Jones</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Moments</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u></u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State) <u></u>			
21. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>1958</u> to <u>Feb 25</u> , 19 <u>62</u> that (I) <u>(the)</u> last saw the deceased alive on <u>JAN. 21th</u> , 19 <u>62</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Dewitt E. DeLawter</u> 22c. PHYSICIAN'S NAME (Type) <u>Dewitt E. DeLawter MD</u>		22b. DATE SIGNED <u>2-25-62</u> 22d. ADDRESS <u>8025 ABERDEEN RD. Bethesda MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 2/26/62</u> 23b. DATE THEREOF <u>2/26/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Salsbury Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Salsbury, North Carolina</u>		25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u></u> DATE <u>1 '62</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

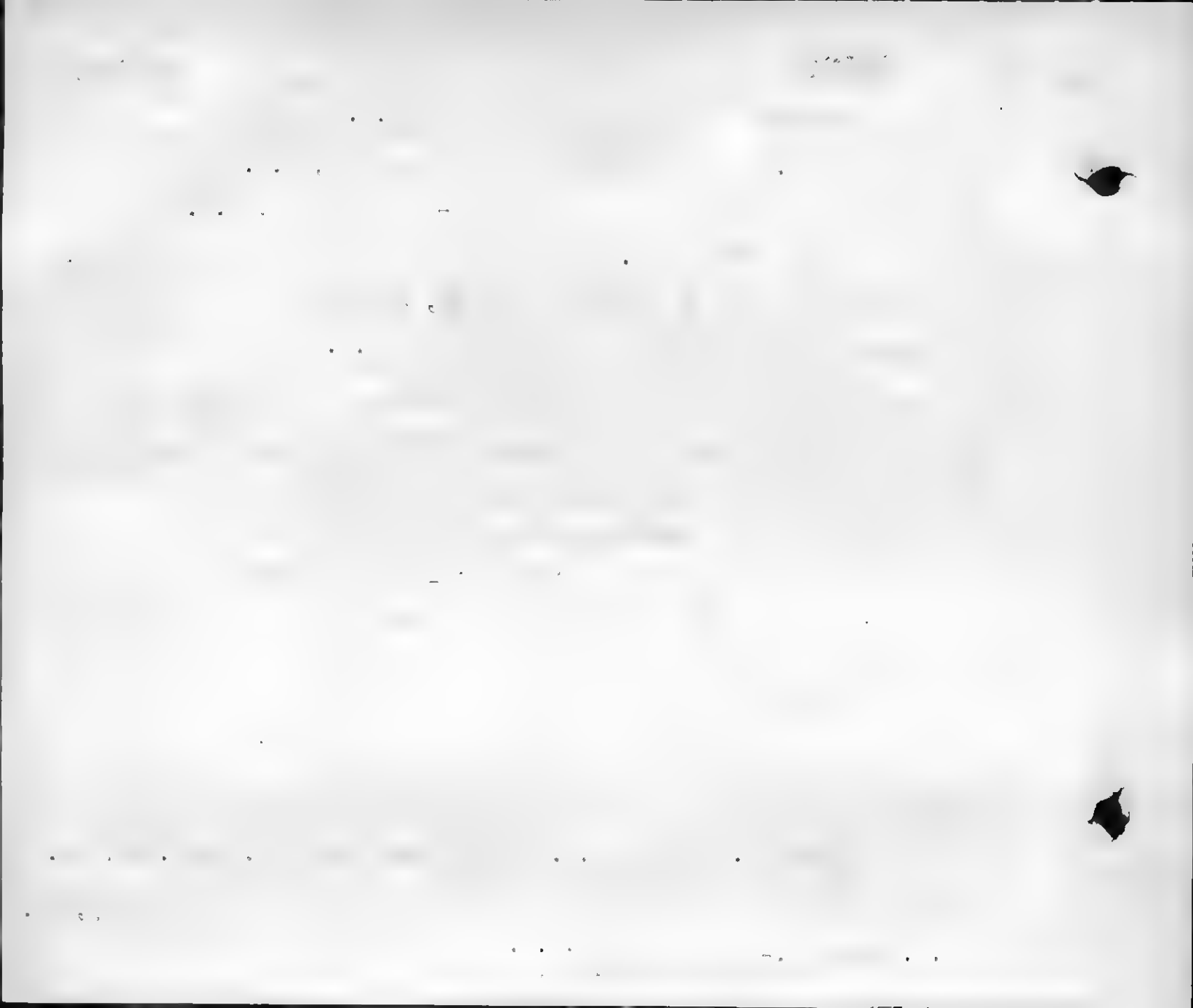
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02121

02104

1. PLACE OF DEATH COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON, MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.	
c. LENGTH OF STAY in lb 9 DAYS		d. STREET ADDRESS 3620 - 16th STREET, N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10231 Carroll Place CARROLL HALL SANITARIUM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLOTTE Middle B. Last NORTON	4. DATE OF DEATH	Month 2 Day 24 Year 1962
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11, 1866
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY OSWEGO, N.Y.	
11. BIRTHPLACE (County & State, or foreign country) OSWEGO, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BENJAMIN GREEN		14. MOTHER'S MAIDEN NAME FLORENCE COMSTOCK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Records at Carroll Hall Sanitarium		Address Same # 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia (b) pulmonary edema (c) arteriosclerotic cardio-vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fracture intertrochanteric left femur on 1/15/62			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 6 19 62 to Feb 24 19 62 that (I) (we) last saw the deceased alive on Feb 23 19 62 , and that death occurred at 2:40 A.M. from the causes and on the date stated above			
22a. SIGNATURE <i>Alfred S. Norton</i>		22b. DATE SIGNED 2/24/62	
22c. PHYSICIAN'S NAME (Type) ALFRED S. NORTON, M.D.		22d. ADDRESS 4711 HIGHLAND AVE. BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 2/27/62	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City, town or county) (State) Prince Georges County, Md.
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		25a. REC'D BY REGISTRAR DATE FEB 26 '62	
ADDRESS 2901 14th St., N.W. Washington 9, D.C.		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02122

CERTIFICATE OF DEATH

02105

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>5123 N. Capitol ST</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Brown</u> Last <u>Payne</u>		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-7-80</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Route agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
13. FATHER'S NAME <u>Wallace Payne</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Ramey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>52582647</u>	
17. INFORMANT <u>Sister - in-law</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <u>Bronchiopneumonia</u> (b) <u>Chronic pulmonary fibrosis</u> (c) <u>12 SX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis severe chronic brain syndrome</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>15 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-4</u> 19 <u>62</u> to <u>2-14</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2-14</u> 19 <u>62</u> , and that death occurred at <u>2:55 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Samuel M. Baggett</u> M.D.		22b. DATE SIGNED <u>2/14/62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Feb 17 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Orleans</u>		23d. LOCATION (City, town or county) (State) <u>Orleans Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Pearson's Funeral Home - To Elye</u>		25a. REC'D BY REGISTRAR <u>Feb 16 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02123

CERTIFICATE OF DEATH

Item 23b, Film G-02 2/26/62 iwk

02106

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit d. STREET ADDRESS 103 D Preston Drive	
3. NAME OF DECEASED (Type or print) Chris Von PEACOCK		4. DATE OF DEATH February 17 1962	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 February 1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 2 yrs
11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cecil Ray Peacock		14. MOTHER'S MAIDEN NAME Cytha Corinna Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT FATHER: Cecil R. Peacock, Same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Prematurity DUE TO 77 6X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 16, 1962 , to Feb. 17, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 17, 1962 and that death occurred at 8:02 PM from the causes and on the date stated above.			
22a. SIGNATURE F.A. Schulaner		22b. DATE 17 February 1962	
22c. PHYSICIAN'S NAME (Type) F.A. SCHULANER, LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 21, 1962	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		25a. REC'D BY REGISTRAR Feb 21 '62	
ADDRESS Rockville Pike, Rockville, Md.		25b. REGISTRAR'S SIGNATURE William S. Flann	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02107

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattstown</u>	
c. LENGTH OF STAY IN 1b <u>14 yrs</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jacob Albert Perry</u>		4. DATE OF DEATH Month Day Year <u>2-12-1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-1904</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. &</u>	
13. FATHER'S NAME <u>Philip K. Perry</u>		14. MOTHER'S MAIDEN NAME <u>Inez Harner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT <u>Moran Perry (son)</u> Address <u>Stun 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Small diag in tel</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-12-62</u>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-15-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East Green</u>	22d. LOCATION (City, town, or country) (State) <u>Luray Va</u>
23. FUNERAL DIRECTOR <u>Edward B. Galtner, Gaithersburg Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Cl. Ing. S. Hume</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02125 CERTIFICATE OF DEATH 02108

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>36 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK 12</u> d. STREET ADDRESS <u>21 Columbia AVE</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude</u> First <u>Eliza</u> Middle <u>Petersen</u> Last		4. DATE OF DEATH <u>Feb.</u> <u>25</u> 19 <u>62</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 - 9 - 78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	9. AGE (In years last birthday) <u>83</u> Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph L. Messery</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Hodges</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Washington San Hosp</u>	
17. INFORMANT <u>Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>586X</u> DUE TO <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Pulmonary failure</u> (c) <u>ruptured Saccular A.A.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>INTERVAL BETWEEN ONSET AND DEATH 1/10/62 - 7/22/62</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> 19 <u>62</u> to <u>Feb 25</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2 - 25</u> 19 <u>62</u> , and that death occurred at <u>3:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>George E. Glick</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type or print) <u>George E. Glick</u>		22d. ADDRESS <u>6826 Reggs Pkwy Hyattsville Md</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 2, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince Geo. County, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Waters</u> ADDRESS <u>254 Carroll St, N.E. Wash, D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 2 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>John D. Pina</u>	



TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. The law requires that the death certificate be retained by the hospital or attending physician. Page 2 of 2. ATTORNEY: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

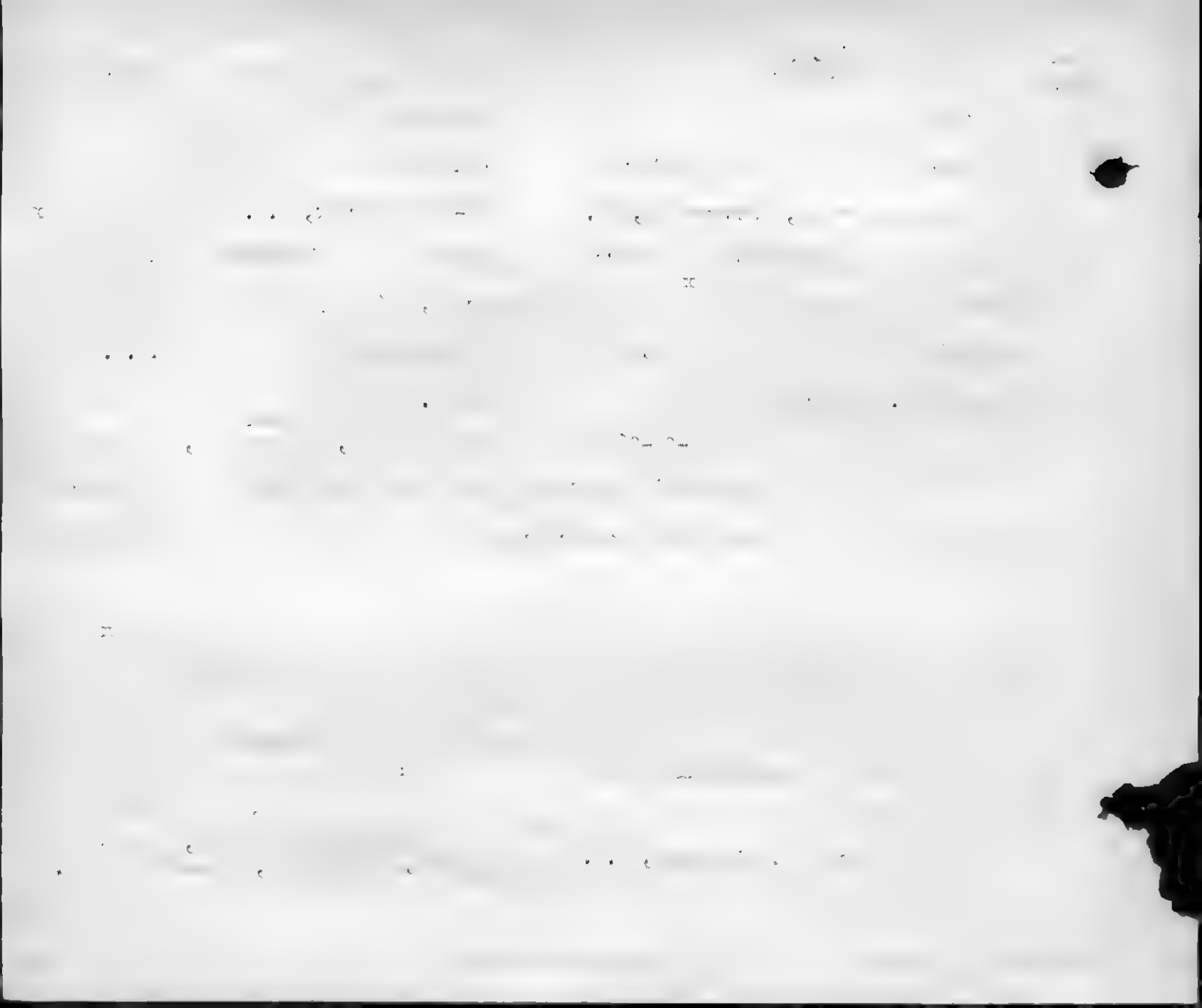
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02126

02103

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 242 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington		b. COUNTY Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		3. NAME OF DECEASED (Type or print) Margaret Lenore Phipps		4. DATE OF DEATH Last First Middle February 11 19 62		5. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Last birth day) Months Days Hours Min. 34 yrs.		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 12, 1927		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Last birth day) Months Days Hours Min. 34 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Washington		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Theodore W. Kenworthy		14. MOTHER'S MAIDEN NAME Mary M. Foster		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 535-24-2678		17. INFORMANT The Medical Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial pressure due to brain metastases DUE TO Conditions, if any, which gave rise to immediate cause (b) Metastatic Choriocarcinoma (c) Metastatic Choriocarcinoma DUE TO cause last, (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 18 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 14 1961 to February 11 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 11 1962 , and that death occurred at 1:50 PM from the causes and on the date stated above.		22a. SIGNATURE M. A. Kirschner		22b. DATE SIGNED 2/12/62		22c. PHYSICIAN'S NAME (Type) Marvin A. Kirschner, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) SHIP - R.R.		23b. DATE THEREOF 2/16/62		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State) WASHINGTON	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS Co.		ADDRESS 1400 CHAPIN ST. N.W. WASHDC		25a. REC'D BY REGISTRAR FEB 19 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02127

02140

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN b. 5 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda
d. STREET ADDRESS 9503 Edgeley Road

3. NAME OF DECEASED (Type or print)
First Arthur Middle F. Last Prior

4. DATE OF DEATH
Month FEB. Day 12 Year 1962

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH
Month MAR. Day 25 Year 1913

9. AGE (in years last birthday) 48 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exhibit maker
11. BIRTHPLACE (County & State or foreign country) U.S. Navy Exhibit Center, Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph B. Prior 14. MOTHER'S MARDEN NAME LILLIE E COWAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 215-03-9017 17. INFORMANT Address (Wife) EMMALYN Prior

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X DUE TO CEREBRAL VASCULAR ACCIDENT
Conditions, if any, which gave rise to immediate cause (b) HYPERTENSION
(c) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY THROMBOSIS 1960
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 1 p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11406 VIERS MILL RD WHEATON MD 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from OCTOBER, 1961, to FEB, 1962 that (I) (was) last saw the deceased alive on FEB 11, 1962, and that death occurred at 4 AM, from the causes and on the date stated above.

22a. SIGNATURE Michael Madole M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED FEB 12 1962

22c. PHYSICIAN'S NAME (Type) 11406 VIERS MILL RD WHEATON MD

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/15/62 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 23d. LOCATION (City, town or county) (State) Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Avenue #29 25a. REC'D BY REGISTRAR 11406 VIERS MILL RD WHEATON MD 25b. REGISTRAR'S SIGNATURE James J. Thomas DATE FEB 14 1962



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

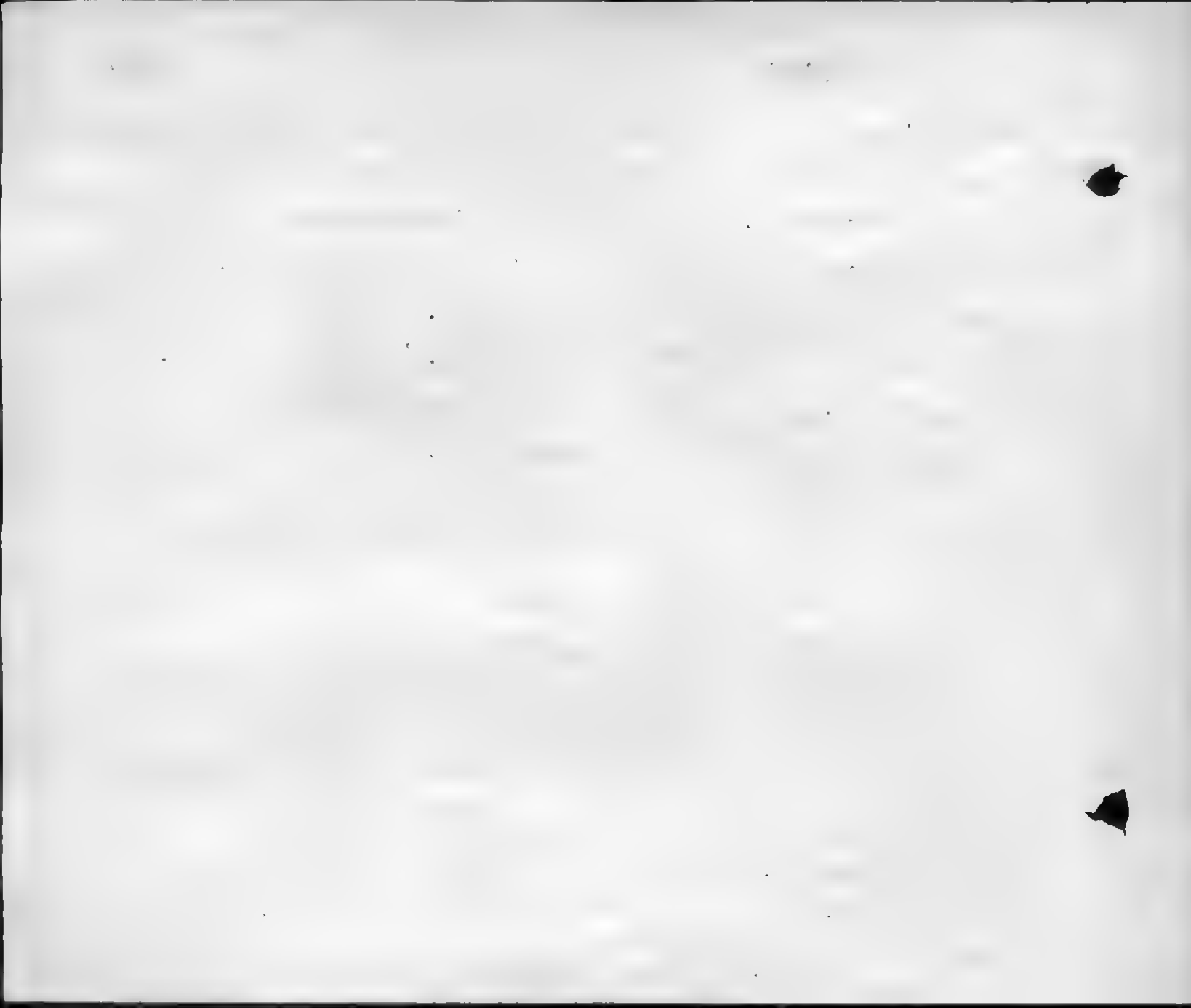
CERTIFICATE OF DEATH

02128

02111

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b. 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.		e. STREET ADDRESS 12511 Atherton Drive		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) John J. QUINLAN		4. DATE OF DEATH FEB. 11 19 62		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 2/14.92		9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (County & State or foreign country) Worcester, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John J. Quinlan		14. MOTHER'S MAIDEN NAME Katherine O'Connor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. YES-COULD NOT SECURE NO.		17. INFORMANT Mrs. Barbara Painter		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause primary for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure 3 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) Uremia due to Neglected Chronic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Uremia due to Neglected Chronic											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Feb 11 1960 to Feb 11 1962 that (I) (we) last saw the deceased alive on Feb 11 1962 and that death occurred at 6:00 PM , from the causes and on the date stated above.											
22a. SIGNATURE John J. Curry MD 22b. DATE SIGNED 2/11/62 22c. PHYSICIAN'S NAME (Type) John J. Curry 22d. ADDRESS 10620 Georgetown Silver Spring											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-15-62 23c. NAME OF CEMETERY OR CREMATORY Blue Hill Cemetery 23d. LOCATION (City, town or locality) (State) Braintree, Massachusetts											
24. FUNERAL DIRECTOR'S SIGNATURE Wm E. Penphly Inc ADDRESS 8434 Georgia Ave, SS, Md 25a. REC'D BY REGISTRAR FEB 14 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thoms											

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

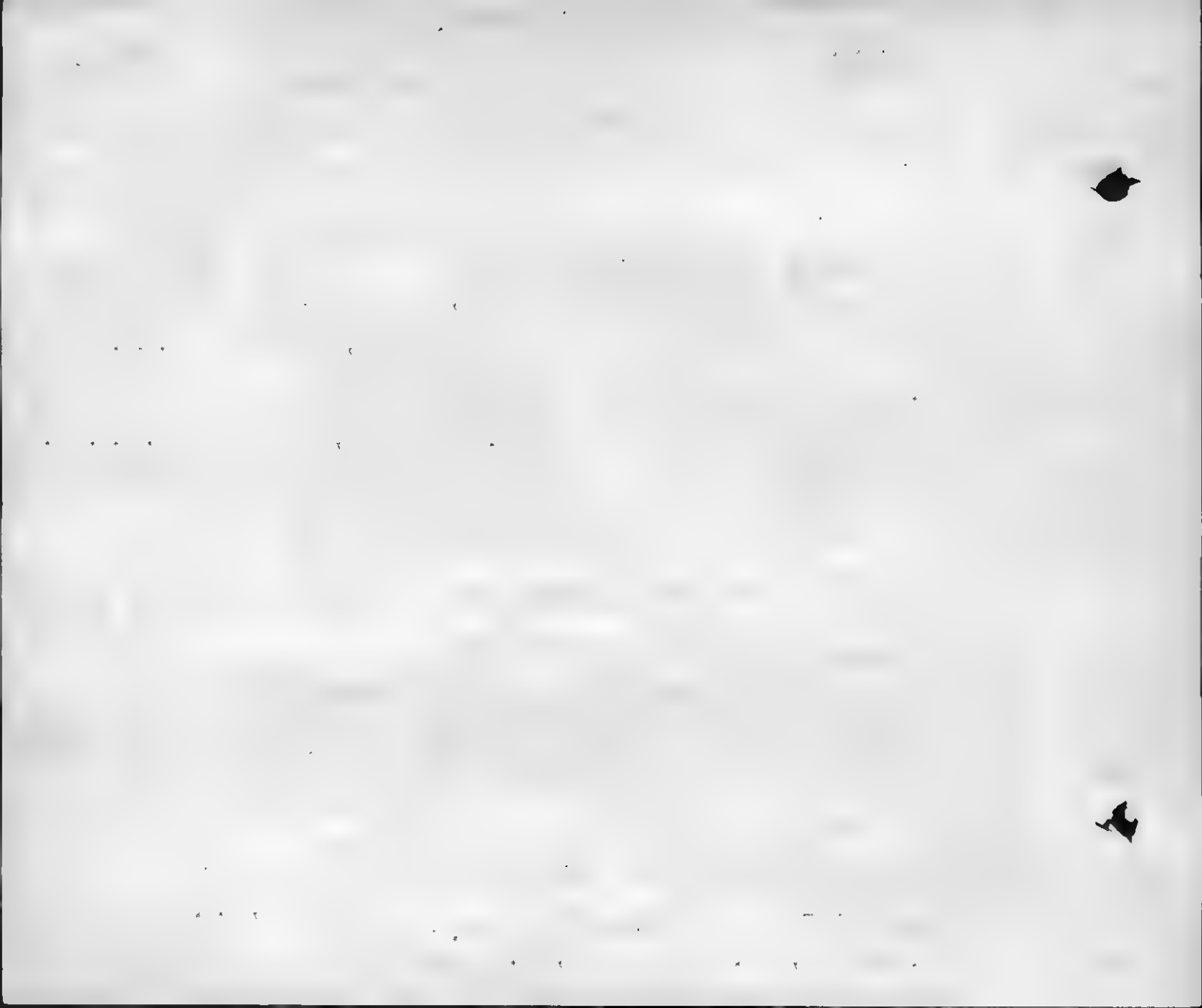
02129 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02112

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN b. <u>5 years</u>				d. STREET ADDRESS <u>106 Hodgen Lane</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>106 Hodgen Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Margaret H. Hodges</u>				4. DATE OF DEATH <u>Feb 26 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1886</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Laurel Grove, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Hodges</u>				14. MOTHER'S MAIDEN NAME <u>Sally Fawcett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John W. Roberts</u> Address <u>12,506 Two Farm Dr. S.S. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1st 2nd + 3rd degree burns</u> DUE TO <u>involving about 80 % of body</u> (b) <u>all clothing completely burned from body</u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Unknown - Probably from cigarettes</u>			
20c. TIME OF INJURY Month, Day, Year <u>2-24-62</u> Hour <u>7</u> p.m.				20d. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.) <u>Home</u>			
20e. CITY OR TOWN <u>Takoma Park</u>				20f. (County) <u>Montgomery</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschaw</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCAW</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-29-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				24a. REC'D BY REGISTRAR <u>WAR 1 '62</u>			
24b. REGISTRAR'S SIGNATURE <u>Raymond C. Zisk</u>				24c. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>			

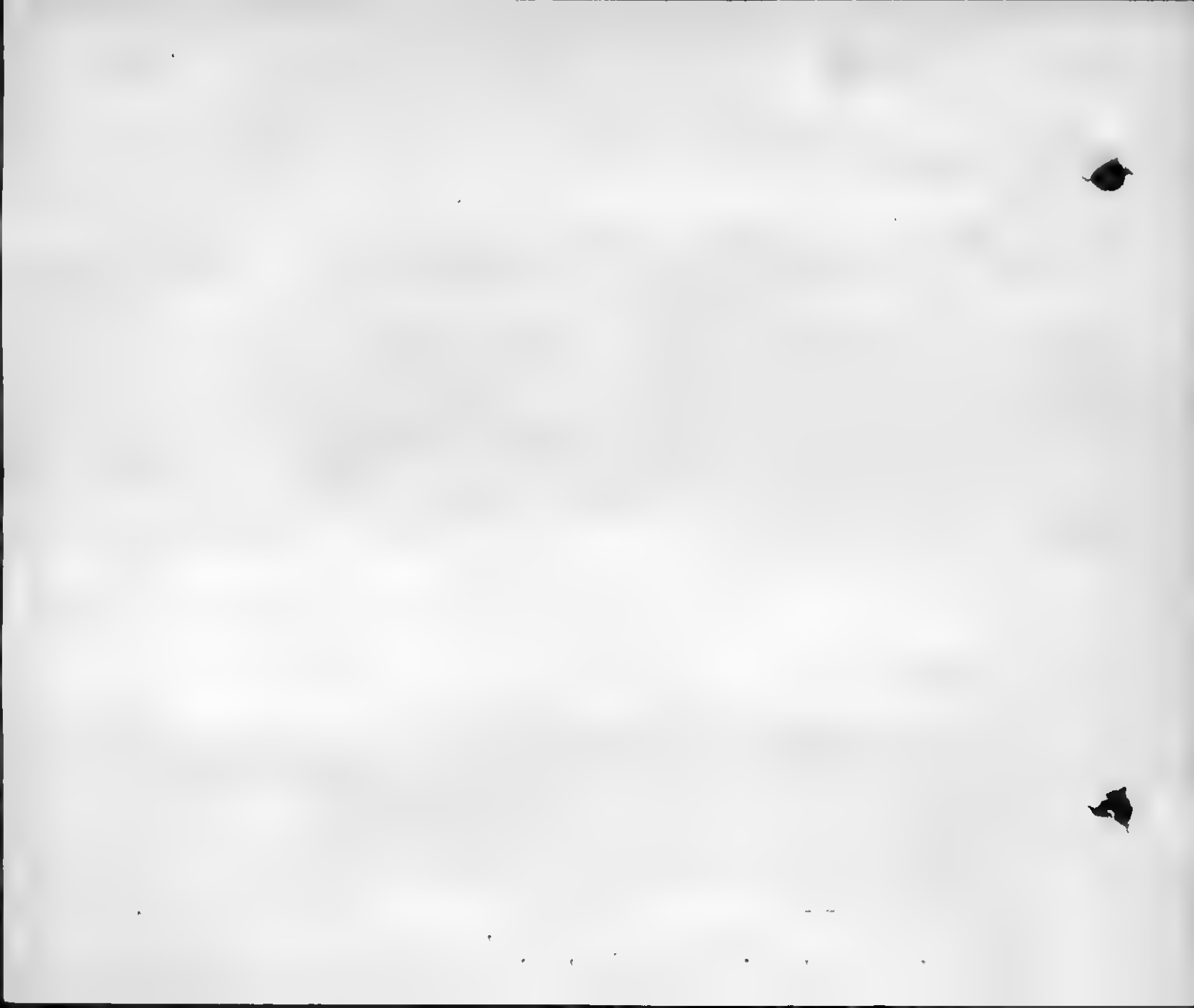


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02130 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02113

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash SAN + Hosp.</u>		d. STREET ADDRESS <u>4502 Furman Rd</u>	
3. NAME OF DECEASED (Type or print) <u>William August Reader</u>		4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-5-05</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electr. Eng.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Vitro LAB</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Reader</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Dahler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>40-03-6398</u>	
17. INFORMANT <u>William A. Reader, Jr.</u>		Address <u>2 D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>20.1</u> (a), stating the underlying cause last, (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>2</u> Day <u>6</u> Year <u>1962</u> Hour <u>2</u> a.m. <u>0</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>2-2-62</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-6-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		22d. LOCATION (City, town, or country) <u>Meriden New Haven Co. Connecticut</u>	
23. FUNERAL DIRECTOR <u>Raymond A. Warner</u>		ADDRESS <u>Georgia Ave., Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>Feb 6 '62</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Thomas</u>	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

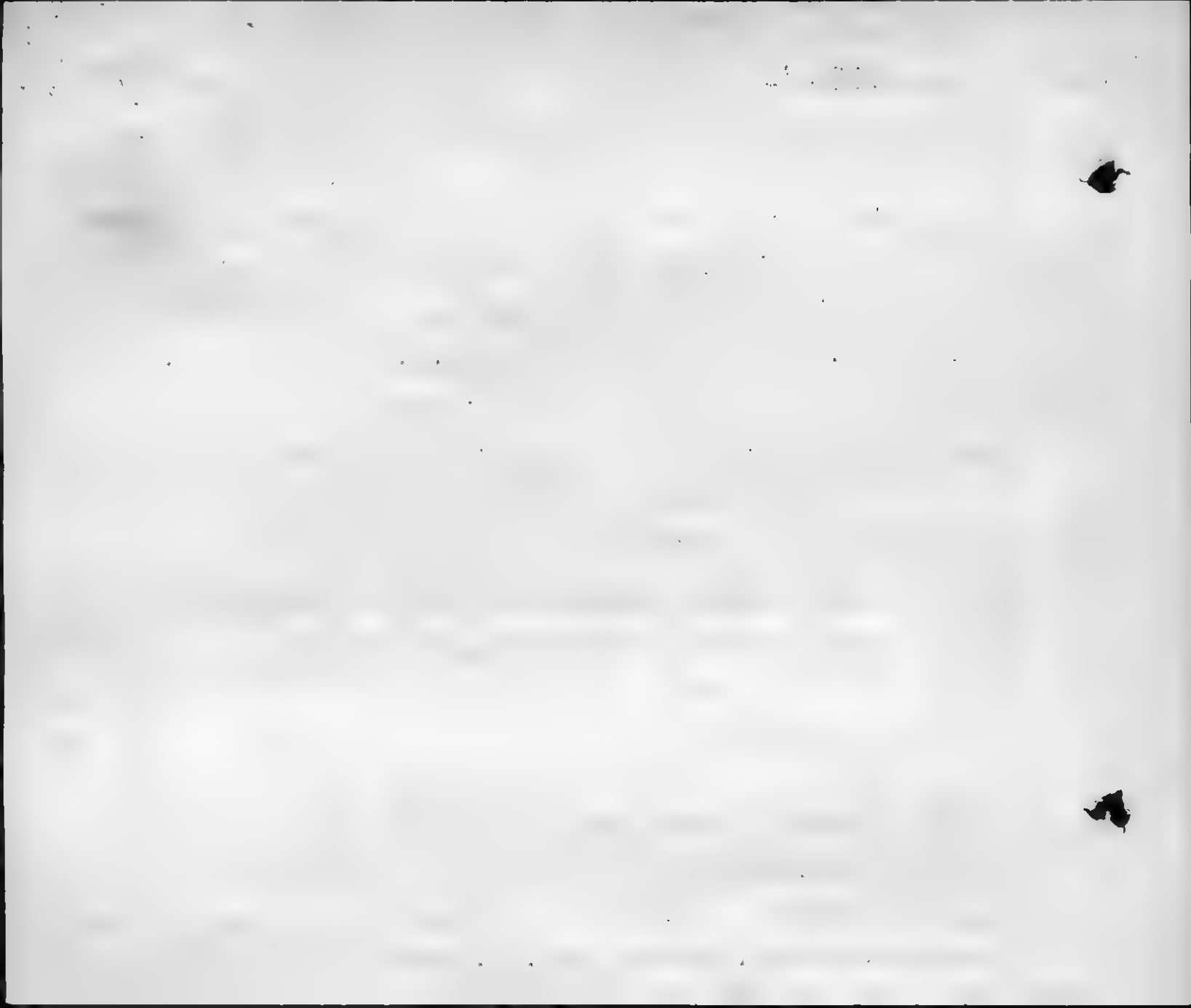
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02131

02114

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if not full-time residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville	
c. LENGTH OF STAY IN 1b 52 Mins		d. STREET ADDRESS 5714 Crawford Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Norman Milton Reed		4. DATE OF DEATH Month Day Year February 6, 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/8/18
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled Vet.	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton Reed		14. MOTHER'S MAIDEN NAME Hazel Grady	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 17. INFORMANT Mother Hazel Reed Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cerebral hemorrhage (multiple) 700.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of skull DUE TO (c) Fall down stairs		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): History of epileptic seizures in the past			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs at home	
20c. TIME OF INJURY Month, Day, Year 6:30 a.m. 2-6 1962		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Rockville monty md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gaus J. Brochart		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Brochart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-6-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-62	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington Va.	
23. FUNERAL DIRECTOR Ernest C. Arthur		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR Feb 8 '62		24b. REGISTRAR'S SIGNATURE Ernest C. Arthur	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



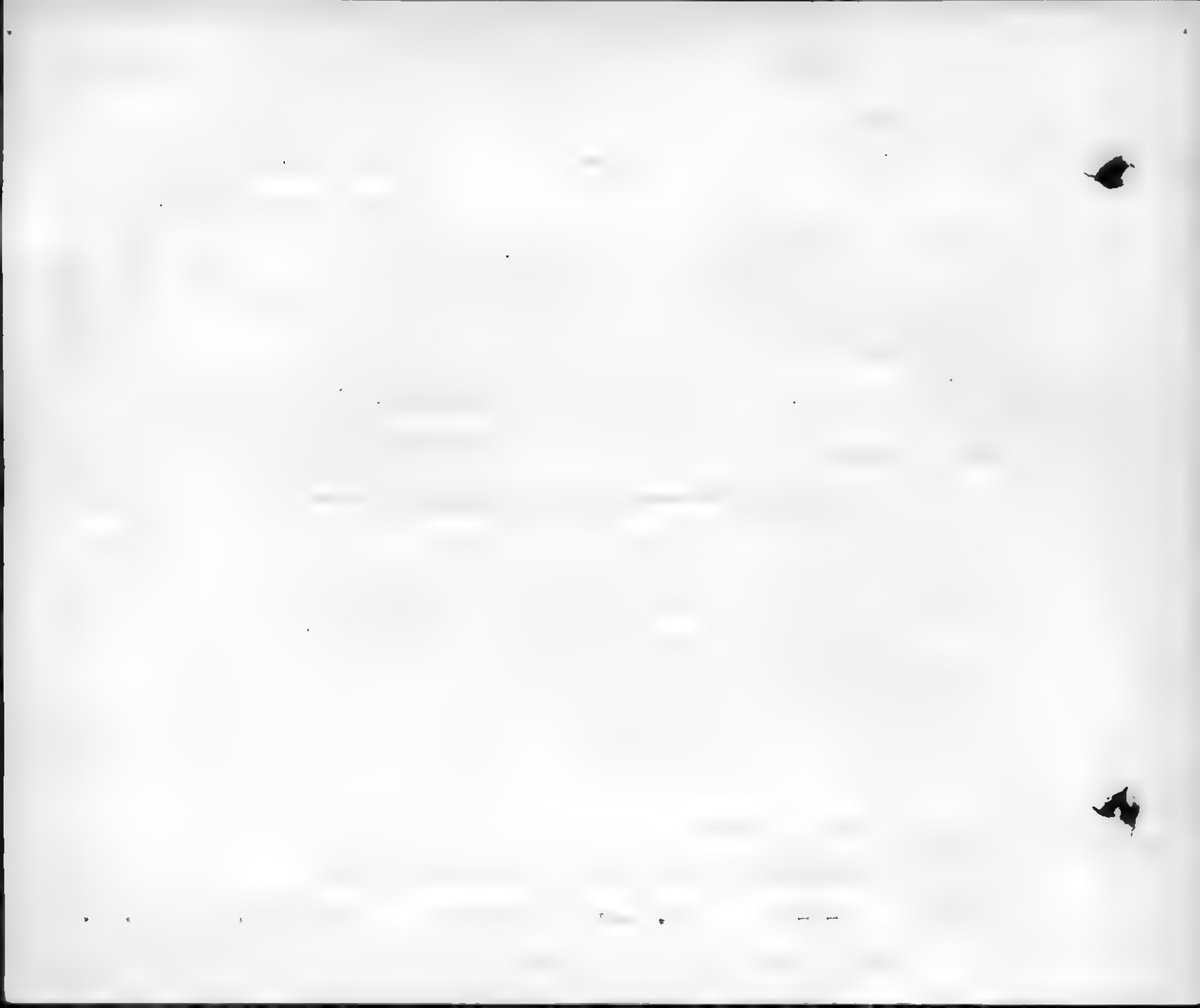
CERTIFICATE OF DEATH

Reg. Dist. No. 02115

02132

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47x2	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS 250 FARRAGUT ST. NW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATRICK Middle J. Last REILLY		4. DATE OF DEATH Month 2 - Day 3 - Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-08
9. AGE (In years last birthday) 53 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	11. BIRTHPLACE (State or foreign country) N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PATRICK J. REILLY	
14. MOTHER'S MAIDEN NAME CORDELIA BUCKLEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES	
16. SOCIAL SECURITY NO.		17. INFORMANT WIFE Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 581.0 Hemorrhage Complicated Varix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 1 , 1962, to Feb 3 , 1962, that I last saw the deceased alive on Feb 3 , 1962, and that death occurred at 1:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3701 Salsburg St. W.D. 0364			
ACTUAL SIGNATURE [Signature]		PHYSICIAN'S NAME (Type) V. R. Raedy M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 2-4-62	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or county) (State) CLAYVILLE, N. Y.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Gollin ADDRESS 3821-14th St. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR Feb 5 '62	24b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02133

02116

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>29 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring,</u> d. STREET ADDRESS <u>8508 - 16th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Faye Beatrice Reiser</u>		4. DATE OF DEATH <u>February 23, 1962</u> Last Middle First Month Day Year	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1 November 1899</u> 9. AGE (in years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Snyderman</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Neumeyer</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No **16. SOCIAL SECURITY NO.** 679-34-7197 **17. INFORMANT** The Medical Records, The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irreversible shock</u> <u>176.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute tubular necrosis</u> (c) <u>Melanoma of Vulva</u>	INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>9 days</u> <u>1 year</u>
---	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from January 25, 1962, to February 23, 1962, that (we) last saw the deceased alive on February 23, 1962, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE <u>Marvin Pomerantz</u> M.D.	22b. DATE SIGNED <u>February 23, 1962</u>
22c. PHYSICIAN'S NAME (Type) <u>Marvin Pomerantz,</u> 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/25/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u>	23d. LOCATION (City, town or county) (State) <u>FALLS CHURCH, VA.</u>
--	---	--	--

24. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>	25a. REC'D BY REGISTRAR <u>FEB 26 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

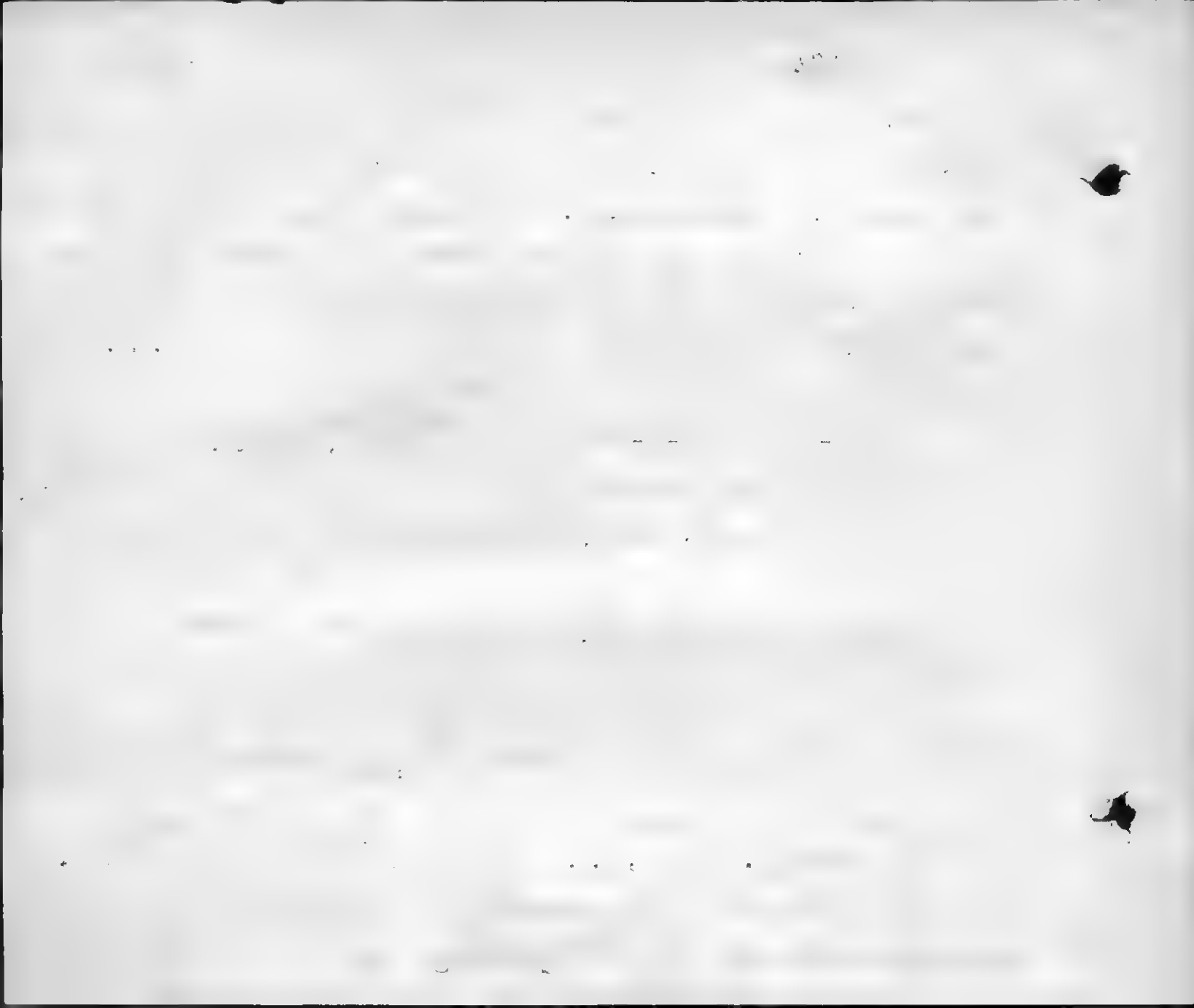
02134

CERTIFICATE OF DEATH

02117

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 56 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY North Syracuse c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Syracuse d. STREET ADDRESS 105 Michael Avenue e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nicholas (First) (No middle name) (Middle) Renne (Last) Male (Sex) White (Color or Race) Machine operator (Usual Occupation) (Not known) (Kind of Business or Industry) Italy (Birthplace) U.S.A. (Citizen of what country)		4. DATE (Month) February (Day) 21 (Year) 1962 DEATH November 5, 1914 (Date of Birth) 47 (Age in years, last birthday) Never Married (Married) Widowed (Divorced)	
13. FATHER'S NAME Tom Renne Yes (Was deceased ever in U.S. Armed Forces?) 1943-1945 (Social Security No.) 134-10-8680		14. MOTHER'S MAIDEN NAME Esther Gallo The Medical Record (Informant) The Clinical Center, Bethesda, 14, Maryland	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Aortic Stenosis and insufficiency DUE TO (c) Total replacement of aortic valve 3 weeks prior to death; pulmonary hypertension of unknown etiology; pulmonary emboli		INTERVAL BETWEEN ONSET AND DEATH 1 hr 20 Min. 7 years	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) 20c. TIME OF INJURY (Month, Day, Year) (Hour a.m. p.m.) 20d. INJURY OCCURRED (While at work Not While at work) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that D (this hospital) attended the deceased from December 27, 1961 to February 21, 1962 , that ON (we) last saw the deceased alive on February 21, 1962 , and that death occurred at 3:50 PM from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard P. Anderson</i> 22c. PHYSICIAN'S NAME (Type) Richard P. Anderson, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 2/22/62 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial 23b. DATE THEREOF 2/26/62 23c. NAME OF CEMETERY OR CREMATORY Assumption 23d. LOCATION (City, town or county) Syracuse N.Y.		25a. REC'D BY REGISTRAR DATE FEB 26 '62 25b. REGISTRAR'S SIGNATURE <i>(Signature)</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

90

MARYLAND STATE DEPARTMENT OF HEALTH

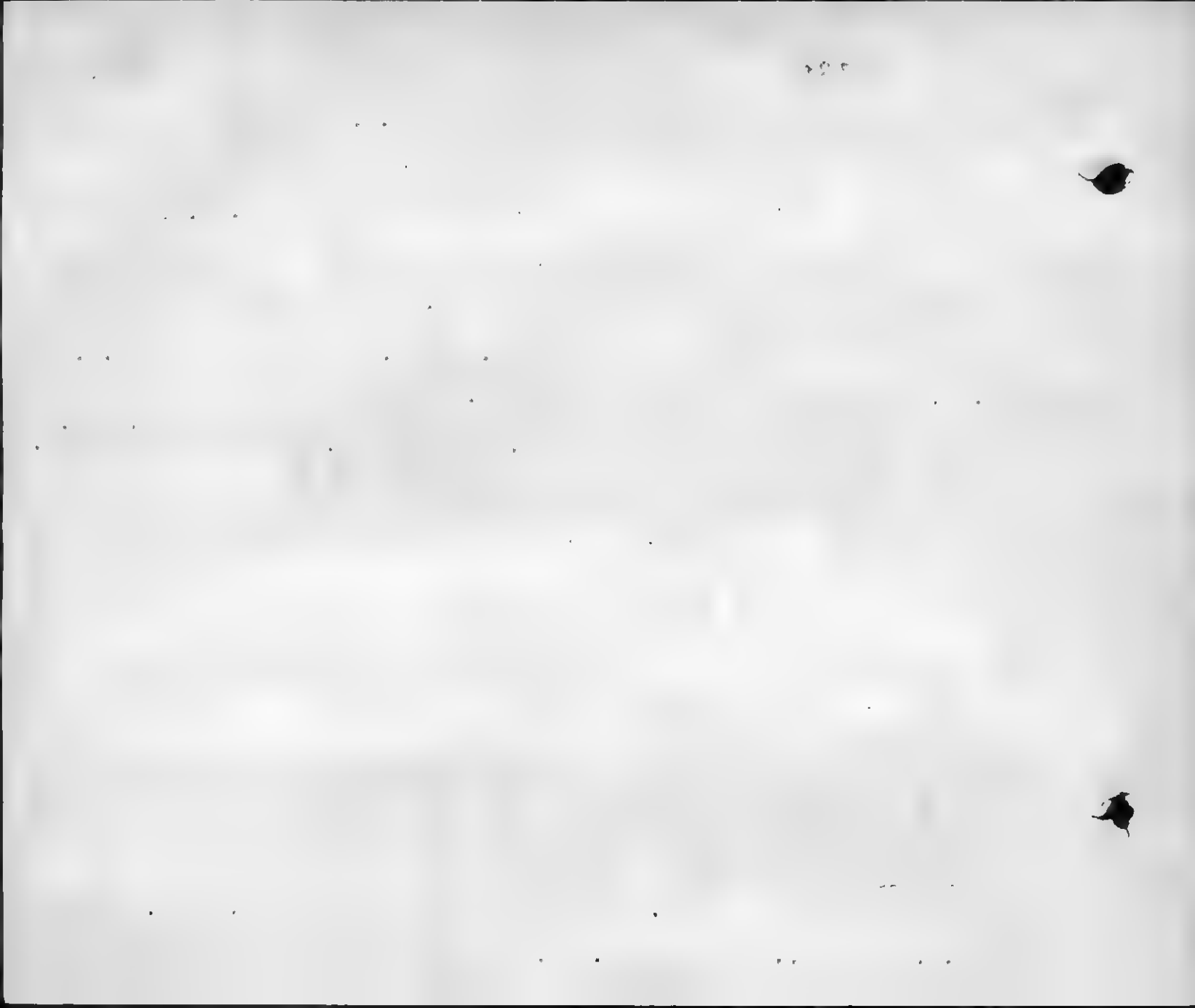
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02135

02118

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>6129 Broad Branch Rd. N.W.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Flora Belle Rives</u>		4. DATE OF DEATH <u>February 7 1962</u>		5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15, 1876</u>		9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS.) <u>85</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Mt. Juliet, Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>W. H. Young</u>				14. MOTHER'S MAIDEN NAME <u>E. Vivietta</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>					
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Ruby Stover, 6129 Broad Branch Rd.</u>				18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Who knows?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10 1962</u> to <u>2/7/1962</u> that (I) (the) last saw the deceased alive on <u>2/7/1962</u> and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Chas H. Wolohon, MD</u>				22b. DATE SIGNED <u>2/7/62</u>				22c. PHYSICIAN'S NAME (Type, <u>Chas H. Wolohon</u>)					
22d. ADDRESS <u>7401 Blair Rd NW Wash D.C.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>2/8/62</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Nashville, Tenn.</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W. Wash, D.C.</u>					
25a. REC'D BY REGISTRAR <u>FEB 9 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>									



VS. A15ME
5M 9/6D

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

DEPUTY FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02120

1 **FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Wheaton

c. LENGTH OF STAY IN 1b

DOA

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

In front of 3005 Newton St.

2. USUAL RESIDENCE (Where deceased lived, if institution; R. s. d. n. c. before admission)

a. STATE

Virginia

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Wheaton Arlington

d. STREET ADDRESS

711 So. 20th Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

William V. Roberson

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9-2-92

9. AGE (In years last birthday)

69 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Navy yard

10b. KIND OF BUSINESS OR INDUSTRY

retired

11. BIRTHPLACE (State or foreign country)

Oklahoma

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes WW-1

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Pearson Funeral Home, Falls Church, Va.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

976X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Cerebral hemorrhage & laceration
bullet wound in rt temple

INTERVAL BETWEEN ONSET AND DEATH

Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Self-inflicted bullet wound in rt temple

20c. TIME OF INJURY

8:15 a.m. 2-2-1962

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Auto

20f. (City or town)

Wheaton

(County)

Montgomery

(State)

MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

2-2-62

SIGNATURE *Frank J. Broschart* M.D.

EXAMINER'S NAME (Type)

FRANK J. BROSCHE

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-6-62

22c. NAME OF CEMETERY OR CREMATORY

Arlington National Cemetery

22d. LOCATION (City, town, or country)

Arlington

(State)

Virginia

23. FUNERAL DIRECTOR

Warner E. Humphrey, Inc. Silver Spring, Md.

ADDRESS 8434 Georgia Ave

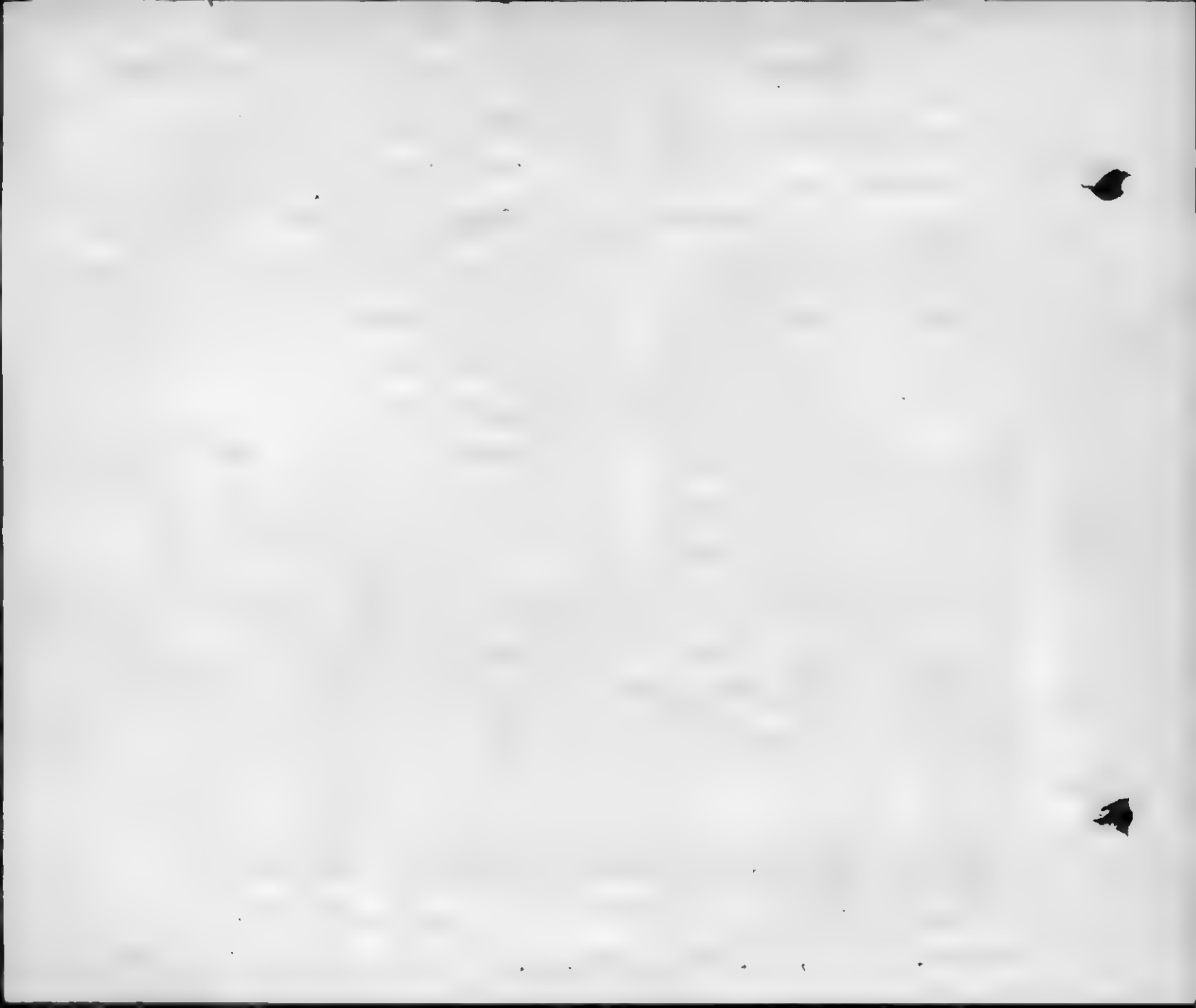
24a. REC'D BY REGISTRAR

DATE FEB 6 '62

24b. REGISTRAR'S SIGNATURE

W. L. Rouse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02138

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02121

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

1 yr

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

5300 Westland Rd. apt 348

2. USUAL RESIDENCE (Where deceased lived, if institution; Res dance before admission)

a. STATE

md

b. COUNTY

Montg

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Bethesda

d. STREET ADDRESS

5300 Westland Rd. apt 348

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

4. DATE OF DEATH

Feb 2 1962

3. NAME OF DECEASED (Type or print)

Ben Palmer Roberson

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-21-1905

9. AGE (In years last birthday)

57 yrs

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer

10b. KIND OF BUSINESS OR INDUSTRY

air cond. Refrig

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jan A Roberson

14. MOTHER'S MAIDEN NAME

Katie S. Drew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

130-09-6504

17. INFORMANT

Stuart Roberson

Address 4735 Chain Bridge Rd McLean Va

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

120.1 DUE TO

Conditions, if any, which gave rise to immediate cause (b)

(c), stating the underlying cause last, DUE TO

(c)

Acute Myocardial Insufficiency Coronary Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Brosch

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

2-3-62

EXAMINER'S NAME (Type)

FRANK J. Brosch

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

2/7/62

22c. NAME OF CEMETERY OR CREMATORY

Arlington Nat. Cem.

22d. LOCATION (City, town, or county)

Arlington, Virginia

(State)

23. FUNERAL DIRECTOR

Robert A. Pumphrey, Bethesda, Maryland

24a. REC'D BY REGISTRAR

DATE FEB 9 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

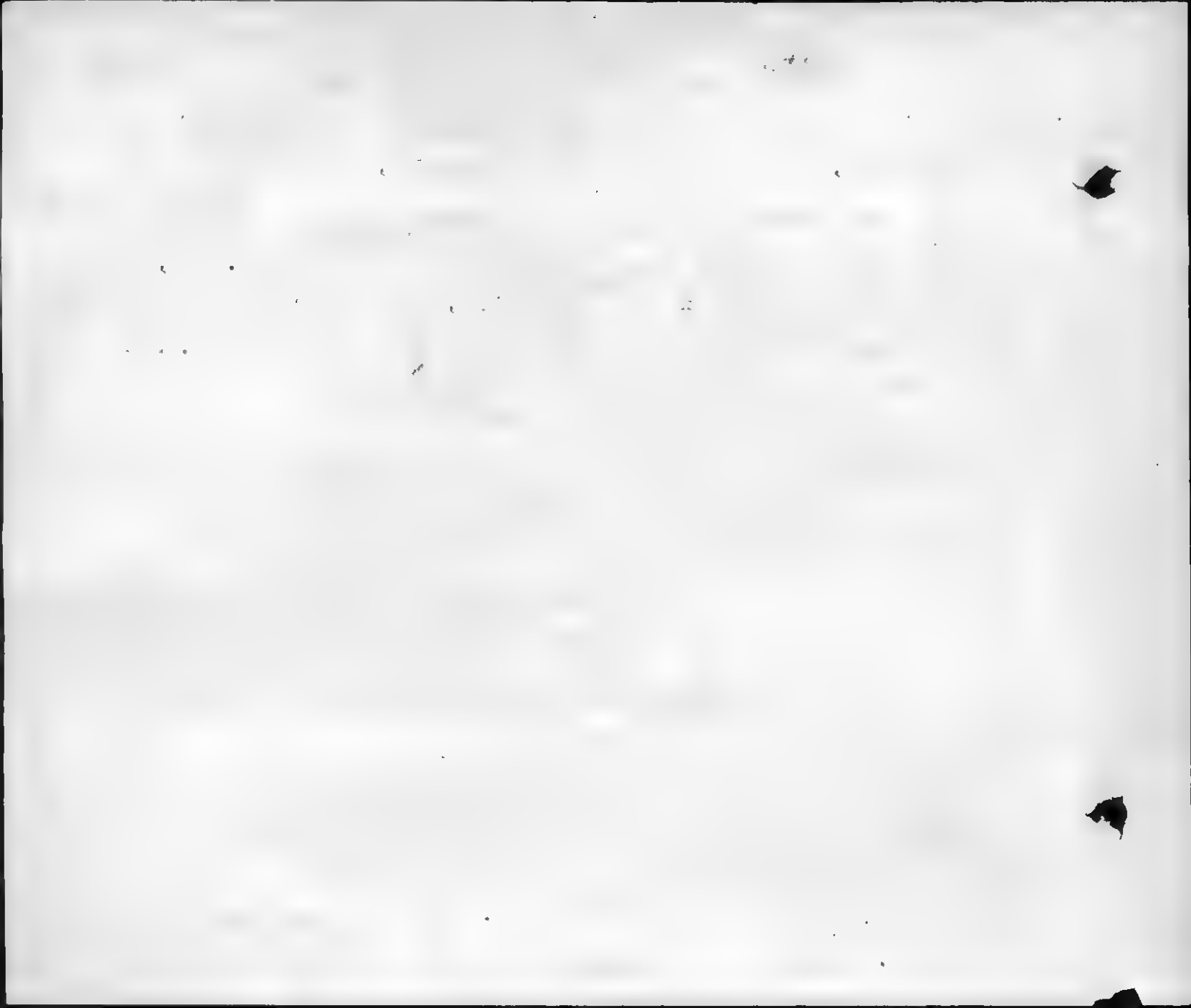
02139

CERTIFICATE OF DEATH

Item 9 film G307 2/19/62 iwk

02122

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN IL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS Horners Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANDERSON		First		Middle		Last ROSS		4. DATE OF DEATH Feb. 3, 1962		Month		Day		Year			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1882		9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Alfred Ross						14. MOTHER'S MAIDEN NAME Adelaine Warren						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease 4-0-0 DUE TO Squamous cell Carcinoma of jaw Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Metastasis To Neck. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from August 1961 to Feb 3, 1962 , that (I) (we) last saw the deceased alive on Feb 1st 1962 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Luciano I. Leal						M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) Luciano I. Leal						22d. ADDRESS Gaithersburg											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/7/62		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.				23d. LOCATION (City, town or county) (State) Rockville, Md							
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden						ADDRESS Rockville, Md		25a. REC'D BY REGISTRAR FEB 13 '62		25b. REGISTRAR'S SIGNATURE Frank							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7-61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

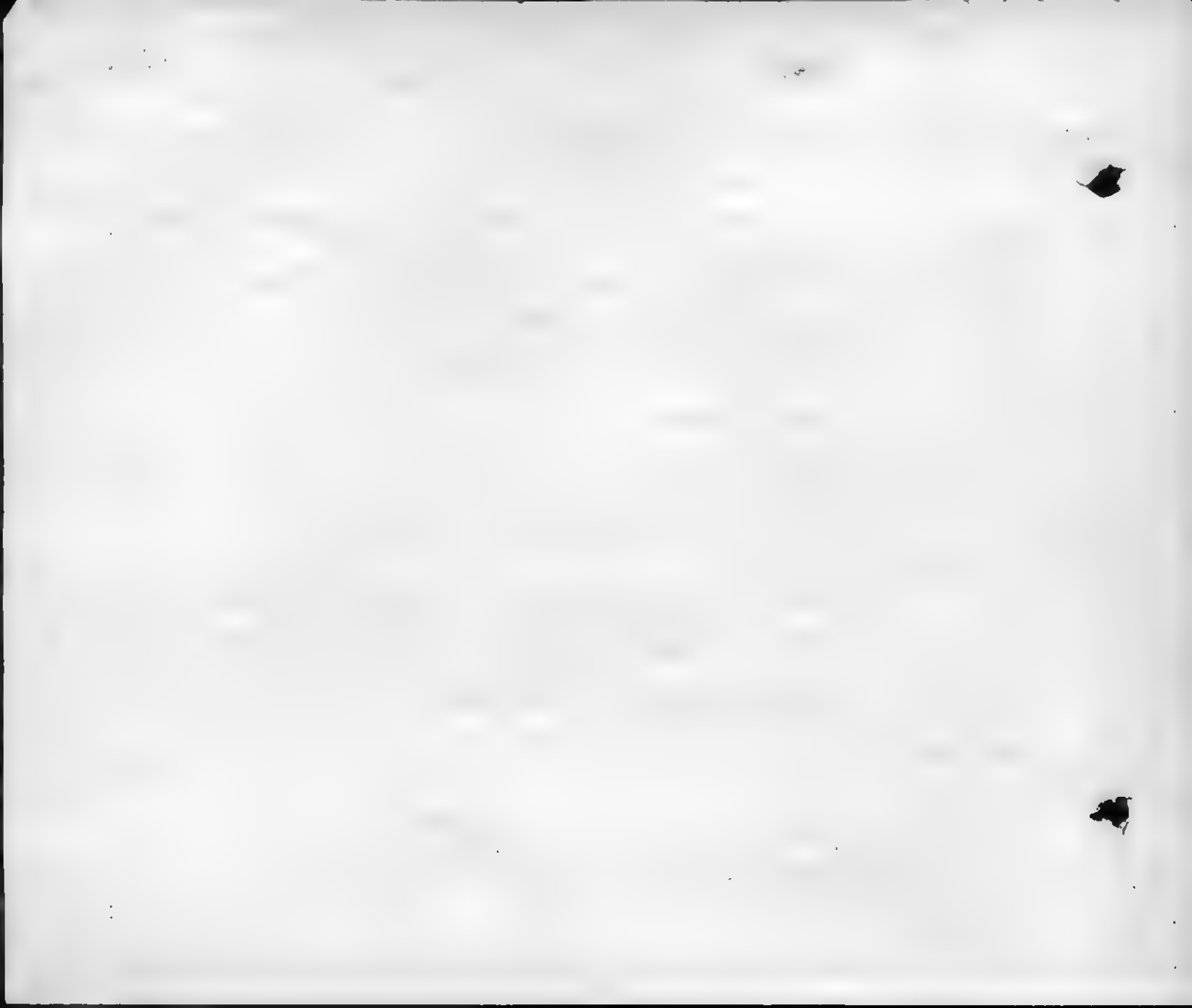
CERTIFICATE OF DEATH

02140

02123

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON, SALTITAKUM & HOSP</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASH D.C. + 183</u> d. STREET ADDRESS <u>718 OGLETHORPE ST NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lenae - Rubinton</u>		4. DATE OF DEATH Last <u>2</u> Month <u>11</u> Day <u>1962</u>		9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		8. DATE OF BIRTH <u>MARCH - 8 - 1883</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Samuel Rubinton</u> Address <u>835 FAIR OAK AVE</u>		18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Arteriosclerosis</u> (c), stating the underlying cause last. <u>4 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
20a. ACCIDENT WAS UNDERLYNG OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)					
21. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> 19 <u>62</u> , and that death occurred at <u>7:40</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Irving W. Winik</u> 22b. DATE SIGNED <u>2/11/62</u>					
22c. PHYSICIAN'S NAME (Type) <u>Irving W. Winik</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2/13/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>DC LODGE Cem</u> 23d. LOCATION (City, town or county) <u>Wash DC</u> (State) <u>—</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Goodberg Funeral Home</u> ADDRESS <u>4217-9th Ave</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>—</u> DATE <u>13 '62</u>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7'61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02141											
02124											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Poolesville c. LENGTH OF STAY IN b 12 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Virginia f. COUNTY Fairfax g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Herndon h. STREET ADDRESS i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Mary Middle Francis Last Rutter						4. DATE OF DEATH Month Feb Day 24 Year 1962					
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH June 7 1878 9. AGE (in years last birthday) 83 IF UNDER 1 YEAR: Months 83 Days 19 Hours 62 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeping--Own home						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) Fairfax Co. Virginia						12. CITIZEN OF WHAT COUNTRY U.S.					
13. FATHER'S NAME Henry Rutter						14. MOTHER'S MAIDEN NAME Francis Lanham					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)						16. SOCIAL SECURITY NO.					
17. INFORMANT Charles Rutter, Poolesville, Maryland						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Influenza, Type Undetermined 4 8 1 X DUE TO Conditions, if any, which gave rise to immediate cause (b). (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 3 days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 24 Jan. 1962 to 24 Feb. 1962 , that (I) (we) last saw the deceased alive on 23 Feb. 1962 , and that death occurred at 9:55 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Gordon M. Smith 22c. PHYSICIAN'S NAME (Type) Gordon M. Smith 22b. DATE SIGNED MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Barnesville, Md.											
23a. BURIAL, CREMATION, REMOVAL Burial 23b. DATE THEREOF 2/27/62 23c. NAME OF CEMETERY OR CREMATORY Chesnut Grove 23d. LOCATION (City, town or county) (State) Herndon, Va.											
24. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton ADDRESS Barnesville, Md. 25a. REC'D BY REGISTRAR FEB 28 '62 25b. REGISTRAR'S SIGNATURE Constance C. Hilton											



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MARYLAND STATE DEPARTMENT OF HEALTH

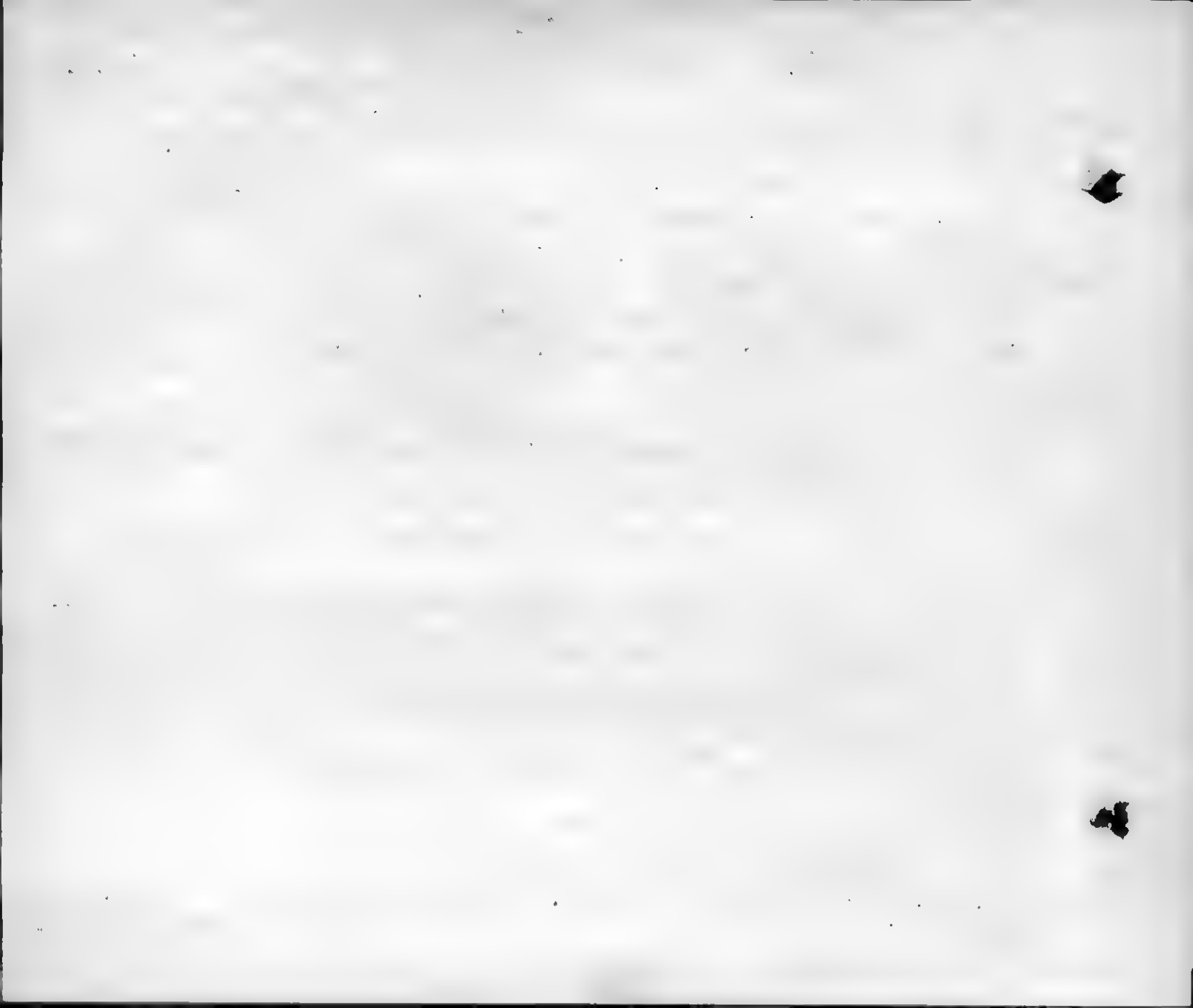
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02142

CERTIFICATE OF DEATH

02125

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN Hb <u>1 mo. 10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanatorium</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u> d. STREET ADDRESS <u>2127 - California St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Lula D. Ryburn</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>7</u> - Year <u>1962</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 3, 1884</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>4</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Clerk - U.S. Govt. - Public Health Ser.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>SMITH COUNTY, VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>F. Grundy Davis</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Snadley</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>NCNE</u>		17. INFORMANT <u>MR. H. F. DAVIS (Bro.)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Insanition - Unknown</u> (b) <u>Myocardial Infarct</u> (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>—</u> 19 <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan 27, 1962</u> to <u>Feb 7, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 5, 1962</u> , and that death occurred at <u>9:30 pm</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Robert T. Thibadeau</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2-7-62</u>							
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>				22d. ADDRESS <u>KENSINGTON, MD 21207</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>FEB. 10/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RICH VALLEY PRES. CH. CEM.</u>		23d. LOCATION (City, town or county) (State) <u>MARION, VIRGINIA</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyung Co.</u>					
24a. ADDRESS <u>1300 - N. 20th St. N.W., WASH. DC</u>				24b. REC'D BY REGISTRAR <u>DATE FEB 13 '62</u>		24c. REGISTRAR'S SIGNATURE <u>P. H. H.</u>		24d. ADDRESS <u>—</u>							



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VR A15 (4)
15M 9/60

2 1
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02143
02126
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Montgomery County MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kesmor Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA
d. STREET ADDRESS 5100 BRADLEY Boulevard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Rolla First RAY Middle SABINE Last
4. DATE OF DEATH FEB Month 26 Day 1962 Year

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Jan. 31, 1891 9. AGE (in years last birthday) 71 yrs. IF UNDER 1 YEAR Months 1 Days 25 IF UNDER 24 HRS. Hours 4 Min. 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Daughtsman 10b. KIND OF BUSINESS OR INDUSTRY U. S. Government 11. BIRTHPLACE (County & State, or foreign country) Nebraska 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Washington Sabine 14. MOTHER'S MAIDEN NAME Elizabeth Fancy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. W.W.I 17. INFORMANT Ada E. Sabine-Wife-Same Item #2 Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal broncho pneumonia
DUE TO (b) Cerebral thrombosis
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. amyotrophic lateral sclerosis
DUE TO (c) 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
10 yrs.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year March 1, 1962 20d. INJURY OCCURRED While ☒ Not While ☐ el work ☐ el work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 22, 1962 to Feb 25, 1962, that (I) (we) last saw the deceased alive on Feb 25, 1962, and that death occurred at 1:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE R. E. Quayle M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 2-25-62
22c. PHYSICIAN'S NAME (Type) R. E. Quayle M.D. 22d. ADDRESS 1822 Bittmore St NW, Washington D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF March 1, 1962 23c. NAME OF CEMETERY OR CREMATORY Hebron 23d. LOCATION (City, town or county) (State) Winchester Virginia

24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland 25a. REC'D BY REGISTRAR 1 '62 25b. REGISTRAR'S SIGNATURE William S. Kline



release autopsy by coroner

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
02144										Reg. Dist. No. 02127			
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 920-NORTHWEST DRIVE						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Emanuel Middle Sachs Last Sachs						4. DATE OF DEATH Month 2 Day 25 Year 1962							
5. SEX m		6. COLOR OR RACE w		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 5, 1892		9. AGE (In years last birthday) yrs 69		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 15 Min 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT-RETIRED						10b. KIND OF BUSINESS OR INDUSTRY LITHUANIA							
11. BIRTHPLACE (State or foreign country) LITHUANIA						12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME YIDEL SACHS						14. MOTHER'S MAIDEN NAME LEAH -							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO 577-48-2270							
17. INFORMANT ROBERT SACHS-8110 TAYLOR DR. S.S. MD.						Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that I attended the deceased from 1/19, 1950 to 2/25, 1962 , that I last saw the deceased alive on 1/9, 1962 , and that death occurred at 3:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3900 McKinley St. N.W. Washington D.C. DATE SIGNED ACTUAL SIGNATURE Irving W. Winik M.D. PHYSICIAN'S NAME (Type) Irving W. Winik													
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2-27-62		22c. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH CEM.				22d. LOCATION (City, town, or county) (State) BALTIMORE MD			
23. FUNERAL DIRECTOR'S SIGNATURE B. Dargatzis						ADDRESS 3501-14th St NW		24a. REC'D BY REGISTRAR DATE FEB 28 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

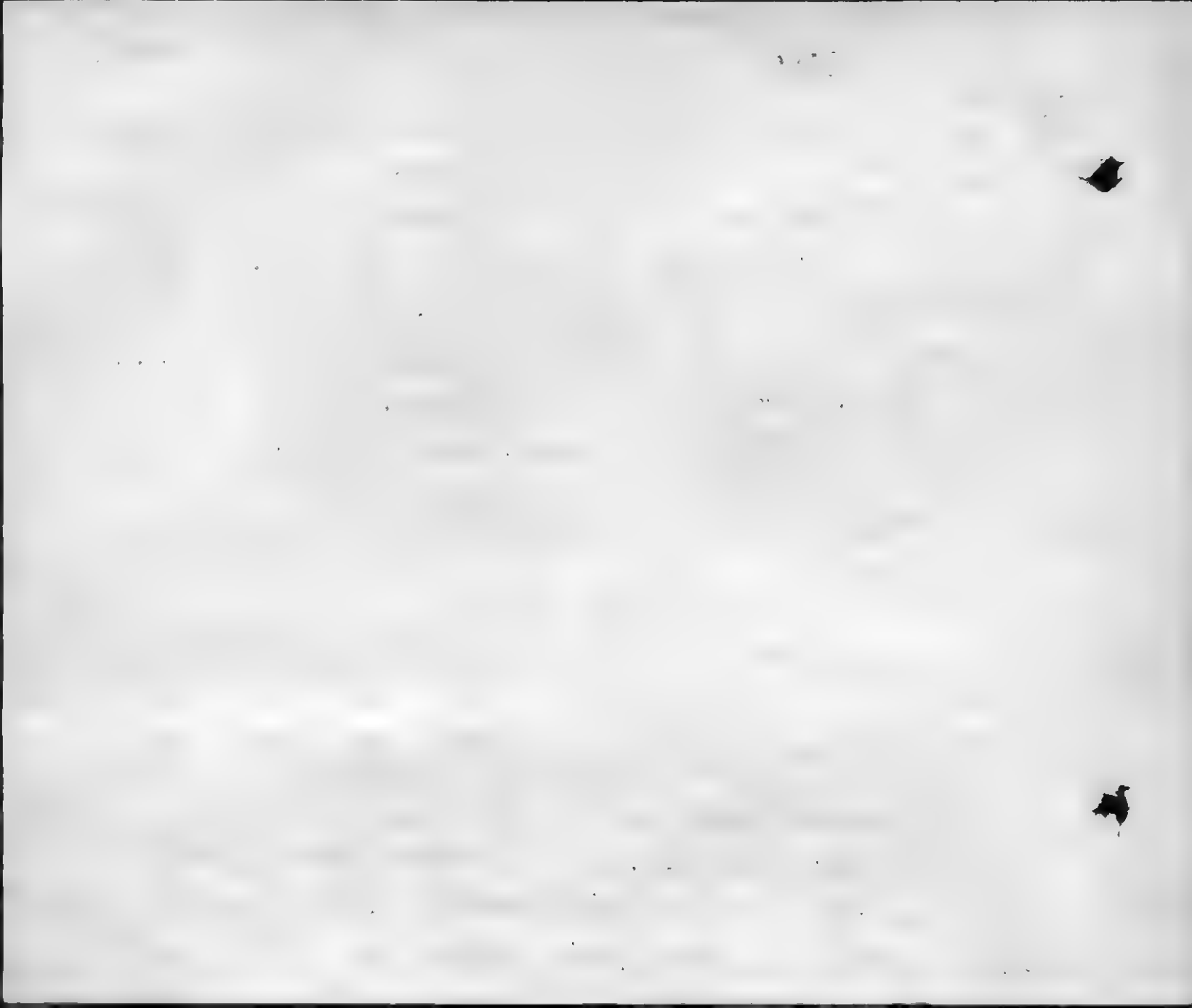


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MONTGOMERY STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02145 CERTIFICATE OF DEATH 02128									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 13 hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park d. STREET ADDRESS 14 Philadelphia Avenue				
3. NAME OF DECEASED (Type or print) Mary Ritchie Scott					4. DATE OF DEATH Feb. 17, 1962				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH August 9, 1877				
9. AGE (In years last birthday) 84 yrs.					10. IF UNDER 1 YEAR: Months 17 Days 17 IF UNDER 24 HRS. Hours 1962 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME David W. Peters					14. MOTHER'S MAIDEN NAME Annie S. Ritchie				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
17. INFORMANT Marian Portillo (daughter)					Address				
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b) and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, early 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) inaction (a), stating the underlying cause last, DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of liver, right.									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]									
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Jan 19 58 to Feb 17 62 , that (I) (we) last saw the deceased alive on 2-16-62 and that death occurred at 3:44 M, from the causes and on the date stated above.									
22a. SIGNATURE Bernard H. Fitzgerald M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 2-17-62									
22c. PHYSICIAN'S NAME (Type) Bernard Fitzgerald, M.D. 22d. ADDRESS 217 Univ. Blvd E, Md.									
23a. BURIAL, CREMATION, 23b. DATE THEREOF Feb. 20, 1962 23c. NAME OF CEMETERY OR CREMATORY First Lincoln Mausoleum 23d. LOCATION (City, town or county) (State) Prince George Co. Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters ADDRESS 254 Carroll St. N.W. Wash DC 25e. REC'D BY REGISTRAR Feb 20 '62 25b. REGISTRAR'S SIGNATURE William S. Riana									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02146
02129
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
c. LENGTH OF STAY IN IL 60 days		d. STREET ADDRESS 813 South Veitch Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha Christina Sergeant		4. DATE OF DEATH February 27 19 62	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 26, 1896 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Washington	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John G. Carlson		14. MOTHER'S MAIDEN NAME Olivie Bahlblon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. HUSBAND: Russell C. Sergeant, Same as #2	
17. INFORMANT HUSBAND: Russell C. Sergeant, Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma parvula 157X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Dec. 29, 19 61 to Feb. 27, 19 62 that (we) last saw the deceased alive on Feb. 27, 19 62 and that death occurred at 11:25 AM from the causes and on the date stated above.			
22a. SIGNATURE Vernon N. Houk		22b. DATE SIGNED February 27, 1962	
22c. PHYSICIAN'S NAME (Type) VERNON N. HOUK LCDR MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/2/62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Walter S. J. J. J. Arlington Funeral Home, 3901 N. Fairfax Dr.		25a. REC'D BY REGISTRAR DATE MAR 5 '62	
25b. REGISTRAR'S SIGNATURE William S. Hanna			



1A13
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02130

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>				d. STREET ADDRESS <u>12412 Oakwood Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash Saint Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Tobias</u> Middle <u>Siegel</u> Last <u>Siegel</u>				4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-29-11-30</u>	
9. AGE (In years last birthday) <u>50</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milkman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>			
11. BIRTH PLACE (State or foreign country) <u>New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Siegel</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Hechstein</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>053-07-0378</u>			
17. INFORMANT <u>Sue Siegel</u>				Address <u>Same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS. STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-8-62</u>							
ACTUAL SIGNATURE <u>Frank J. Bluschant</u> M.D.				EXAMINER'S NAME (Type) <u>FRANK J. BLUSCHANT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>2/11/62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>MONTEFIORE CEM.</u>				22d. LOCATION (City, town, or country) (State) <u>QUEENS, N.Y.</u>			
23. FUNERAL DIRECTOR <u>Sealing Funeral Home</u>				24. REC'D BY REGISTRAR <u>4217-9th</u>			
24b. REGISTRAR'S SIGNATURE <u>13 '62</u>				24c. REGISTRAR'S SIGNATURE <u>13 '62</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
02148		Item 9 Film G508		3/13/62 iwk		02131				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont. Co.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>					
c. LENGTH OF STAY IN 1b <u>18 days</u>					d. STREET ADDRESS <u>7415 Lynnhaven</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Lynne C. Smeby</u>					4. DATE OF DEATH <u>Feb. 28, 1962</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/1/03</u>		AGE (in years, months, days) <u>58 yrs.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>radio engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Communications</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.H.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.H.</u>				
13. FATHER'S NAME <u>Herold Smeby</u>					14. MOTHER'S MAIDEN NAME <u>Minnie Peterson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO <u>no</u>					
17. INFORMANT <u>Evelyn Smeby</u>					Address <u>As above</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarct, rt. lower lobe</u>										
DUE TO (b) <u>Thrombosis, pulmonary artery, rt. lower lobe branch</u>										
DUE TO (c) <u>Hypertensive heart disease with cor bovinum</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>FEB. 28, 1962</u> to <u>2/28, 1962</u> , that (I) (we) last saw the deceased alive on <u>2/28, 1962</u> , and that death occurred <u>10:15 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Charles J. Jurek</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Charles J. Jurek</u>					22d. ADDRESS <u>1015</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-3-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) <u>WASHINGTON</u>		(State) <u>D.C.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Peta T. Solomon</u>					25a. REC'D BY REGISTRAR <u>5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>5 '62</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with this State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

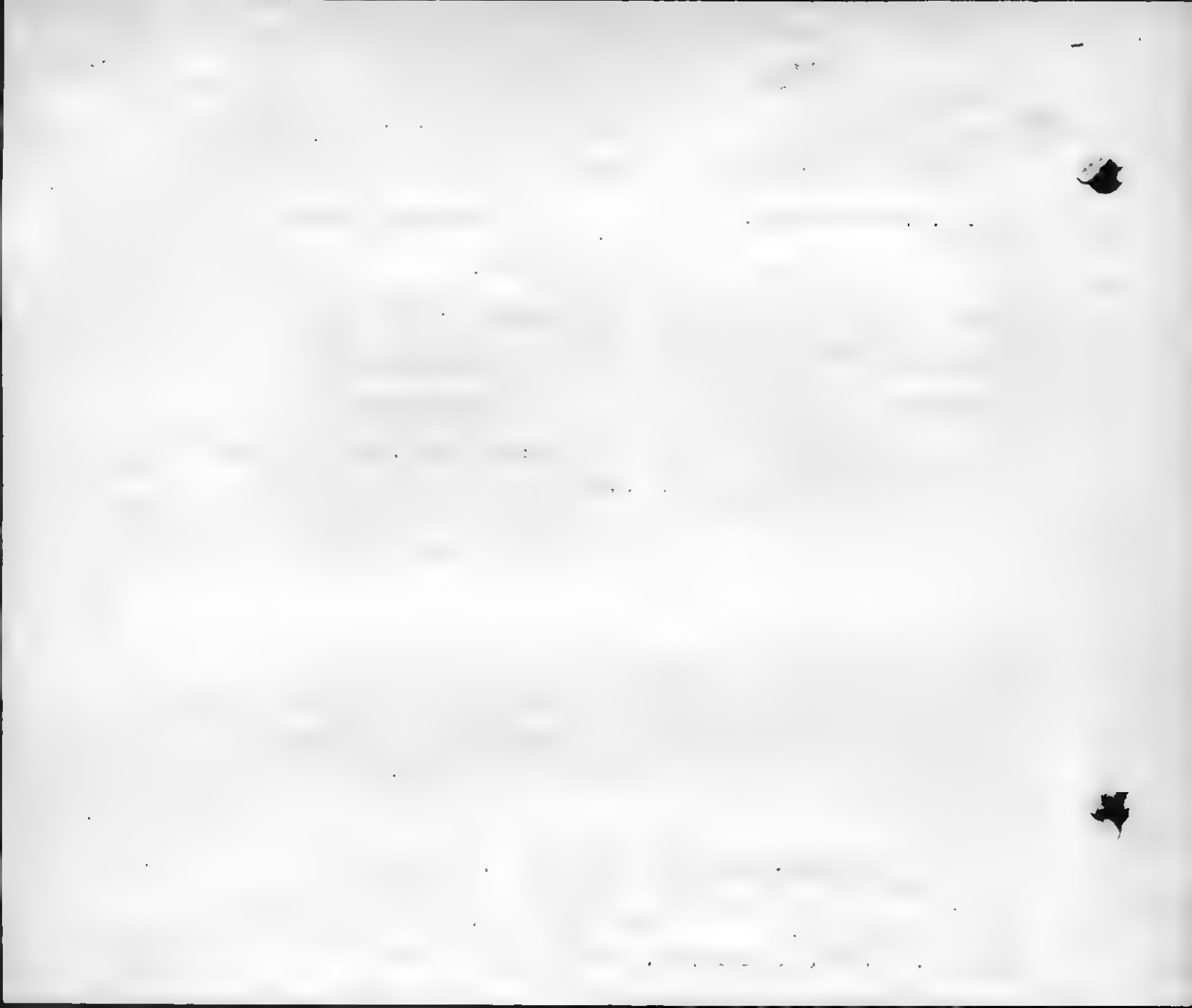
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02149

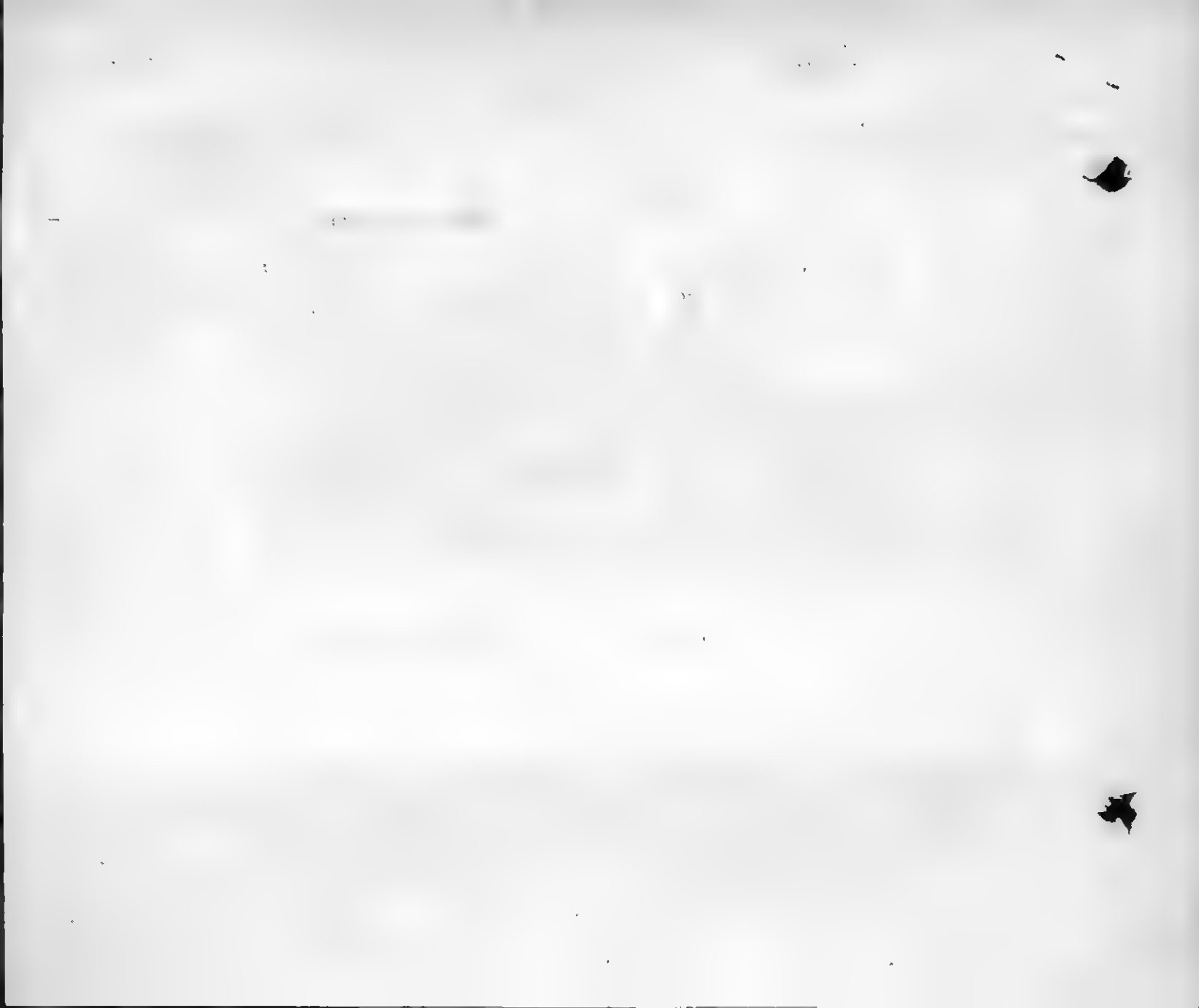
02132

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY in 1b 8 days		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE D. C.		b. COUNTY Washington	
3. NAME OF DECEASED (Type or print) U. S. Naval Hospital,		4. DATE OF DEATH Month Day Year February 5, 1962		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. BIRTH DATE Month Day Year August 28, 1876		9. AGE (In years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer		11. BIRTHPLACE (Country & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smith		14. MOTHER'S MAIDEN NAME Mary Armstrong		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. SON: William G. Smith Jr., Same as #2		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Prostate with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1962	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Jan. 28, 1962 to Feb. 5, 1962		20g. (County) 11:00AM		20h. (State) 1962	
21. I certify that (this hospital) attended the deceased from Jan. 28, 1962 to Feb. 5, 1962 , that (we) last saw the deceased alive on Feb. 5, 1962 , and that death occurred at 11:00AM from the causes and on the date stated above.		22a. SIGNATURE Joseph H. Eusterman		22b. DATE February 5, 1962		22c. PHYSICIAN'S NAME (Type) JOSEPH H. EUSTERMAN LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-9-62		23c. NAME OF CEMETERY OR CREMATORY Arlington		23d. LOCATION (City, town or county) Arlington, Va.		23e. (State) VA.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. ADDRESS Beth., Md.		24b. REC'D BY REGISTRAR FEB 7 '62		24c. REGISTRAR'S SIGNATURE Arthur S. Kraus		24d. DATE FEB 7 '62	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02150					02133				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>Montgomery</u>					a. STATE <u>Md</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					b. COUNTY <u>Montgomery</u>				
c. LENGTH OF STAY IN lb <u>23 days</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Kensington</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban hospital</u>					d. STREET ADDRESS <u>3924 Baltimore Street</u>				
3. NAME OF DECEASED (Type or print) <u>Ida M. Snyder</u>					4. DATE OF DEATH <u>Feb. 11 1962</u>				
5. SEX <u>F</u>					6. COLOR OR RACE <u>W</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>9/26/83</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Gort, Wash. D.C.</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>M.S.A.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>George H. H.</u>					14. MOTHER'S MAIDEN NAME <u>Meredith</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>Niece - C. Campbell</u>				
17. INFORMANT <u>Niece - C. Campbell</u>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>arterio sclerosis</u> (e), stating the underlying cause last, DUE TO <u>cardio vascular renal disease</u> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>cholecystectomy, excision of kidney cyst 1-29-62</u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1-19-62</u> to <u>2-11-62</u> , that (I) (we) last saw the deceased alive on <u>2-11-62</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>John O. Robben M.D.</u>					22b. DATE SIGNED <u>2-11-62</u>				
22c. PHYSICIAN'S NAME (Type) <u>John O. Robben</u>					22d. ADDRESS <u>10511 Summit Ave. Kensington, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>2/15/62</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>					25a. REC'D BY REGISTRAR <u>FEB 15 '62</u>				
					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02151

CERTIFICATE OF DEATH

02134

M

PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits,

write RURAL and give nearest town)
Bethesda (Rural)

c. LENGTH OF STAY IN TB

6 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF

(Type or print)

First

John

Middle

E. D.

Last

Snyder

4. DATE

OF DEATH

Month

February 20,

Day

Year

19 62

5. SEX

Male

6. COLOR OR RACE

Caucasian

7. MARRIED

☒ NEVER MARRIED ☐DIVORCED ☐

8. DATE OF BIRTH

May 10, 1920

9. AGE (In years

last birthday)

41 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School Teacher

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Snyder

14. MOTHER'S MAIDEN NAME

Katherine Wise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

Yes

WW II

16. SOCIAL SECURITY NO.

173 18 7987

17. INFORMANT

Hospital Records

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Myocardial Infarction Acute and Chronic

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that ☒ (this hospital) attended the deceased from ... Feb. 14, 1962 to ... Feb. 20, 1962 that (ix) (we) last saw the deceased alive on ... Feb. 20, 1962 ... and that death occurred 12:55 AM from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

WILLIAM P. BAKER LT MC USN

M.D.

ATTENDING PHYS. ☐MED. DIRECTOR ☐STAFF PHYS. ☒

22b. DATE SIGNED

February 20, 1962

22d. ADDRESS

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

2/24/62

23c. NAME OF CEMETERY OR CREMATORY

Hill Crest Cemetery

23d. LOCATION (City, town or county)

Clearfield, Penna.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Humphrey Funeral Home, 7557 Wisc. Ave.,

ADDRESS

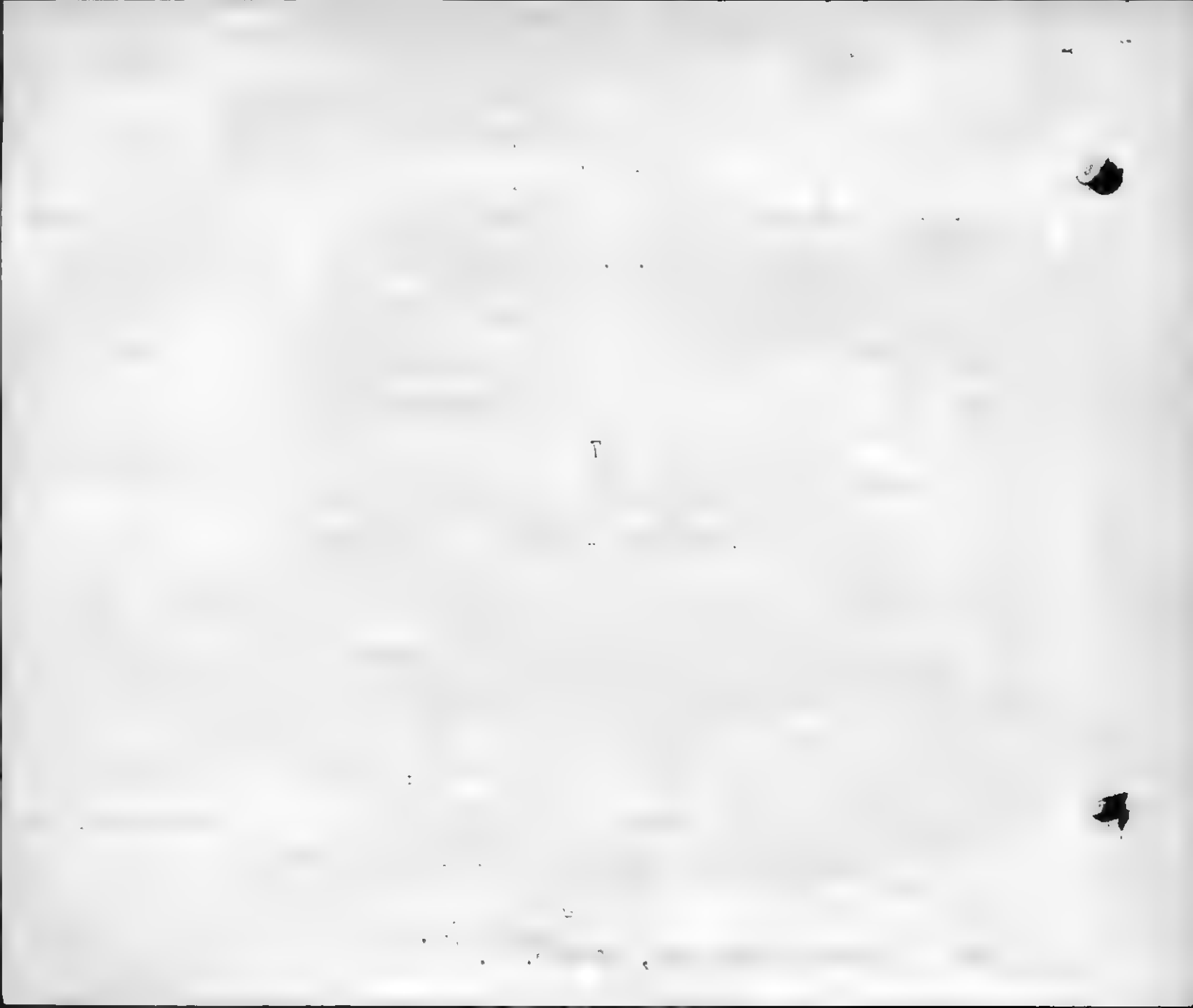
Bethesda, Md.

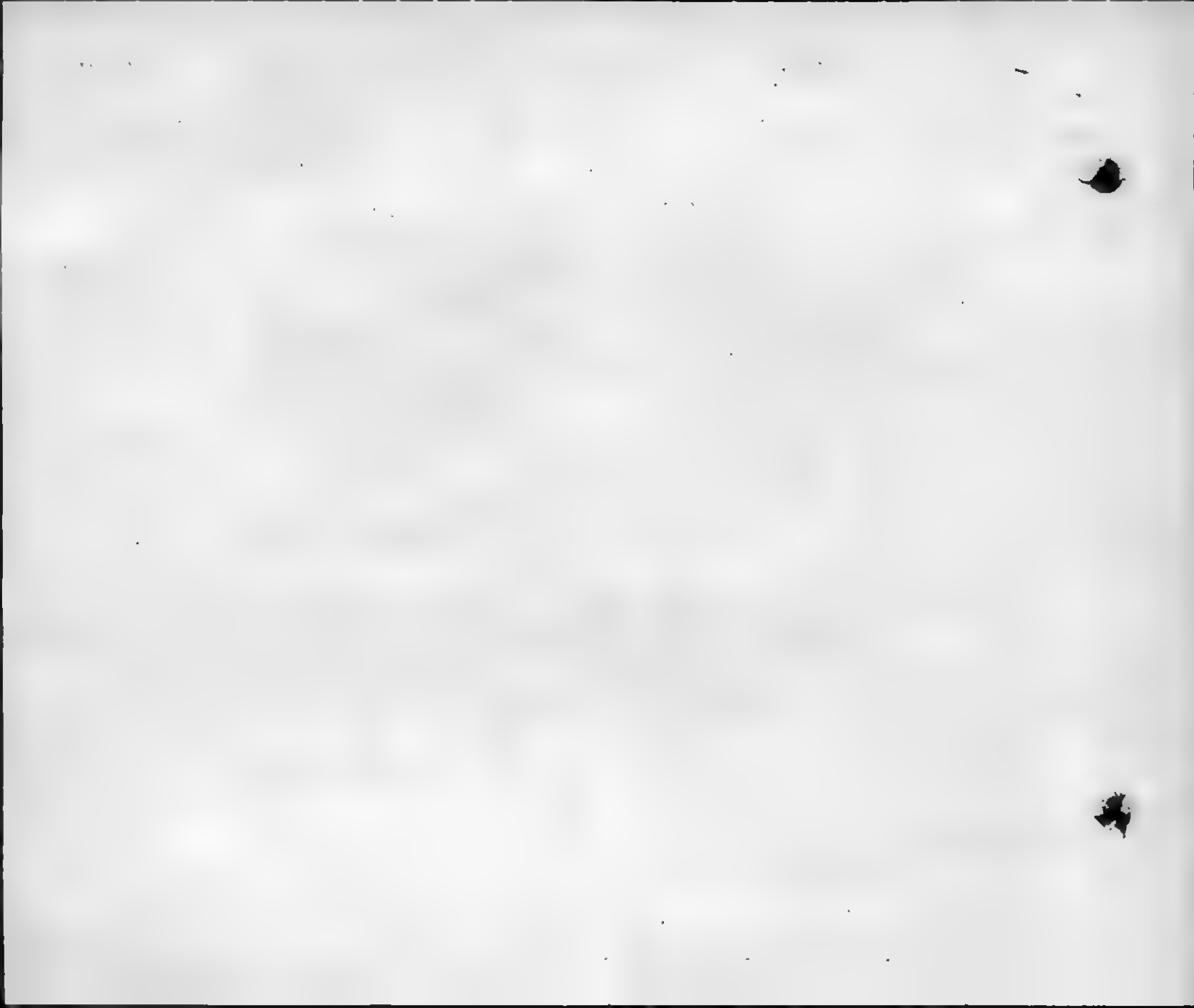
REC'D BY REGISTRAR

DATE FEB 23 '62

25b. REGISTRAR'S SIGNATURE

Clement S. Kenna





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

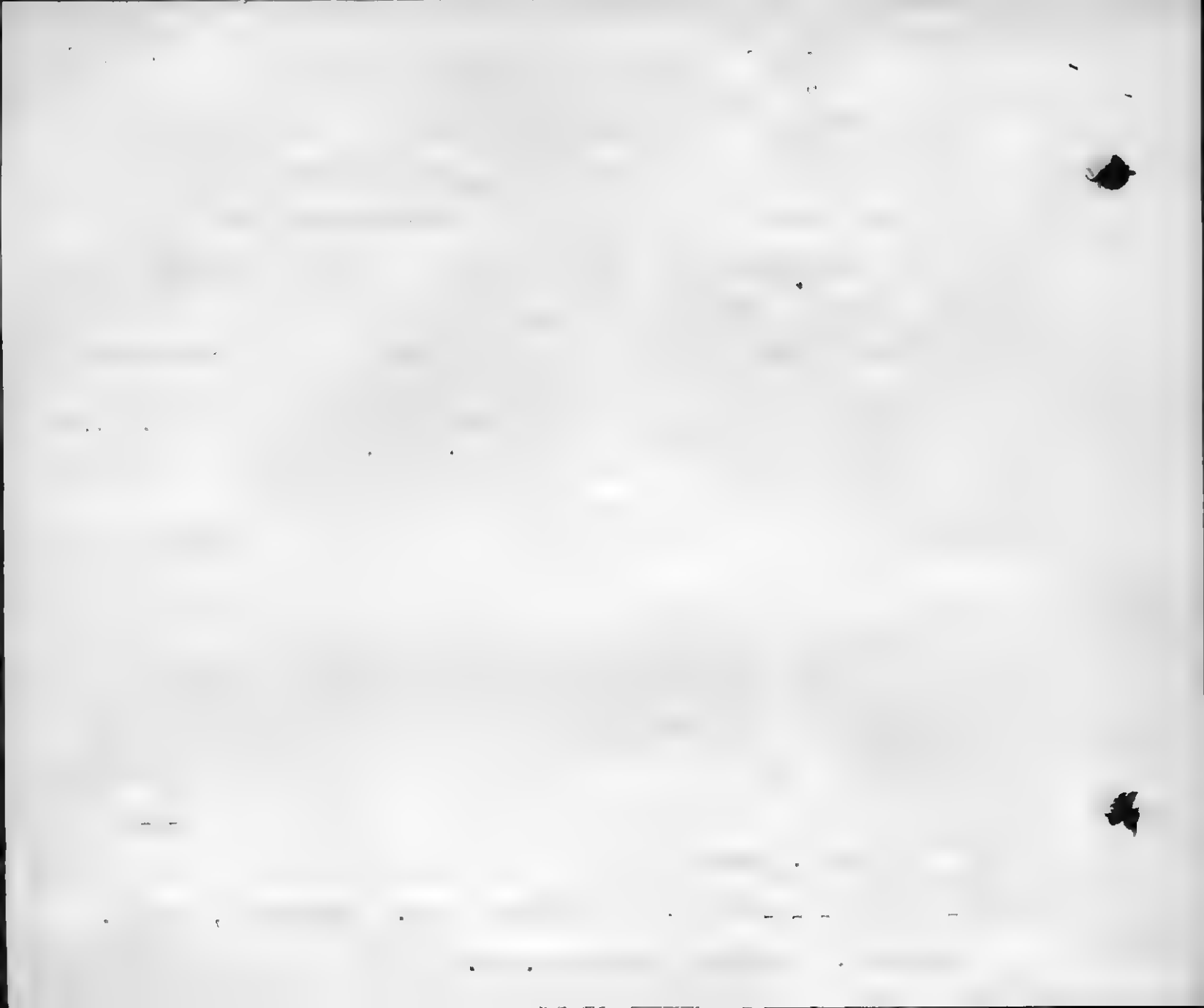
02153

CERTIFICATE OF DEATH

02136

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 5 1/2 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital				e. STREET ADDRESS 10410 Inwood Avenue			
3. NAME OF DECEASED (Type or print) First Aleksandra Middle Stankunas Last Stankunas				4. DATE OF DEATH Month February Day 2 Year 19 62			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/18/82	
9. AGE (in years last birthday) 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? Naturalized US				13. FATHER'S NAME Alex Yutz			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Francis C. Stann, 2518 Plyers Mill Rd., Sil. Sp., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis Secondary to Arteriosclerosis 1 year</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> </div> <div style="width: 35%;"> <p>DUE TO (b) 4 days</p> <p>DUE TO (c) 1 year</p> </div> </div>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 2 1955 to Feb 2 1962 that (I) (we) last saw the deceased alive on Feb 2 1962 and that death occurred 2:25 P.M. from the causes and on the date stated above							
22a. SIGNATURE John J. Curry M.D.				22b. DATE SIGNED 2-2-62		22c. PHYSICIAN'S NAME (Type) JOHN J. CURRY	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit -2-2-62		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY St. Mary Magdelene Cem.		23d. LOCATION (City, town or county) (State) Homestead, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				25a. REC'D BY REGISTRAR DATE FEB 7 '62			
ADDRESS Bethesda, Md.				25b. REGISTRAR'S SIGNATURE William L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM
5M 9/60

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>02154</p> </div> <div> <p>02137</p> <p>Items 1, 6 & 7 fill in G-08 3/7/62 iwk</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville (rural)</u></p> <p>c. LENGTH OF STAY IN TB <u>D.O.A.</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>at scene of suicide</u></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Md</u> b. COUNTY <u>Montg</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u></p> <p>d. STREET ADDRESS <u>15520 Wooten Ave</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print) <u>Alfred Francis Stanton Jr</u></p>			<p>4. DATE OF DEATH <u>Feb 23 1962</u></p>			<p>5. SEX <u>Male</u></p>			<p>6. COLOR OR RACE <u>White</u></p>		
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>			<p>8. DATE OF BIRTH <u>10-23-35</u></p>			<p>9. AGE (In years last birthday) <u>26 yrs</u></p>			<p>IF UNDER 1 YEAR: Months <u>2</u> Days <u>6</u></p> <p>IF UNDER 24 HRS: Hours <u>2</u> Min. <u>6</u></p>		
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u></p>				<p>11. BIRTHPLACE (State or foreign country) <u>New York</u></p>			
<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>											
<p>13. FATHER'S NAME <u>Alfred Francis Stanton</u></p>						<p>14. MOTHER'S MAIDEN NAME <u>Helena Dykstra</u></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Korean</u></p>						<p>16. SOCIAL SECURITY NO. <u>262-46-9255</u></p>					
<p>17. INFORMANT <u>Helena Stanton-Item# 2</u></p>						<p>Address</p>					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u></p> <p>978X DUE TO (b) <u>Bullet wound Thru skull</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>											
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound Thru skull</u></p>							
<p>20c. TIME OF INJURY Month, Day, Year <u>2-23 1962</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/></p>				<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wooten Rd Rockville Montg Md</u></p>			
<p>20f. (City or town) <u>Rockville</u></p>				<p>(County) <u>Montg</u></p>				<p>(State) <u>Md</u></p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>											
<p>ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.</p>						<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>					
<p>EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u></p>						<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>					
<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>						<p>DATE SIGNED <u>Feb 23-62</u></p>					
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>bur-transit</u></p>				<p>22b. DATE THEREOF <u>2/28/62</u></p>				<p>22c. NAME OF CEMETERY OR CREMATORY <u>Pine Lawn National</u></p>			
<p>22d. LOCATION (City, town, or country) <u>Long Island, New York</u></p>				<p>(State) <u></u></p>							
<p>23. FUNERAL DIRECTOR <u>Lyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.</u></p>						<p>ADDRESS</p>					
<p>24a. REC'D BY REGISTRAR <u>FEB 27 '62</u></p>						<p>24b. REGISTRAR'S SIGNATURE <u>C. J. 8</u></p>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, P, M, and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

02155

02138

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u> g. STREET ADDRESS <u>#4 Taylor, Carver Heights</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KIMBERLEE LEVERN STOUT</u> i. SEX <u>Female</u> j. COLOR OR RACE <u>Negroid</u> k. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> l. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> m. KIND OF BUSINESS OR INDUSTRY <u>None</u>		4. DATE OF DEATH <u>February 7, 1962</u> n. AGE (In years last birthday) <u>2</u> o. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> p. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Donald William Stout</u> q. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> r. SOCIAL SECURITY NO. <u>None</u> s. INFORMANT <u>Dorothy Louise Jackson</u> t. ADDRESS <u>Hospital Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <u>Prenatality</u> (b) DUE TO <u>776X</u> (c) DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>11</u> p.m. <u>54</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>Feb. 5, 1962</u> , to <u>Feb. 7, 1962</u> , that <u>10</u> (we) last saw the deceased alive on <u>Feb. 7, 1962</u> , and that death occurred at <u>11:54 AM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Bernard H. Feldman</u> b. PHYSICIAN'S NAME (Type) <u>BERNARD H. FELDMAN LT MC USN</u>		22b. DATE SIGNED <u>February 7, 1962</u> c. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> d. DATE THEREOF <u>2-9-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> e. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. F. Taylor</u> f. ADDRESS <u>909 6th ST. WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>FEB 9 '62</u> g. REGISTRAR'S SIGNATURE <u>W. L. P. P.</u>	



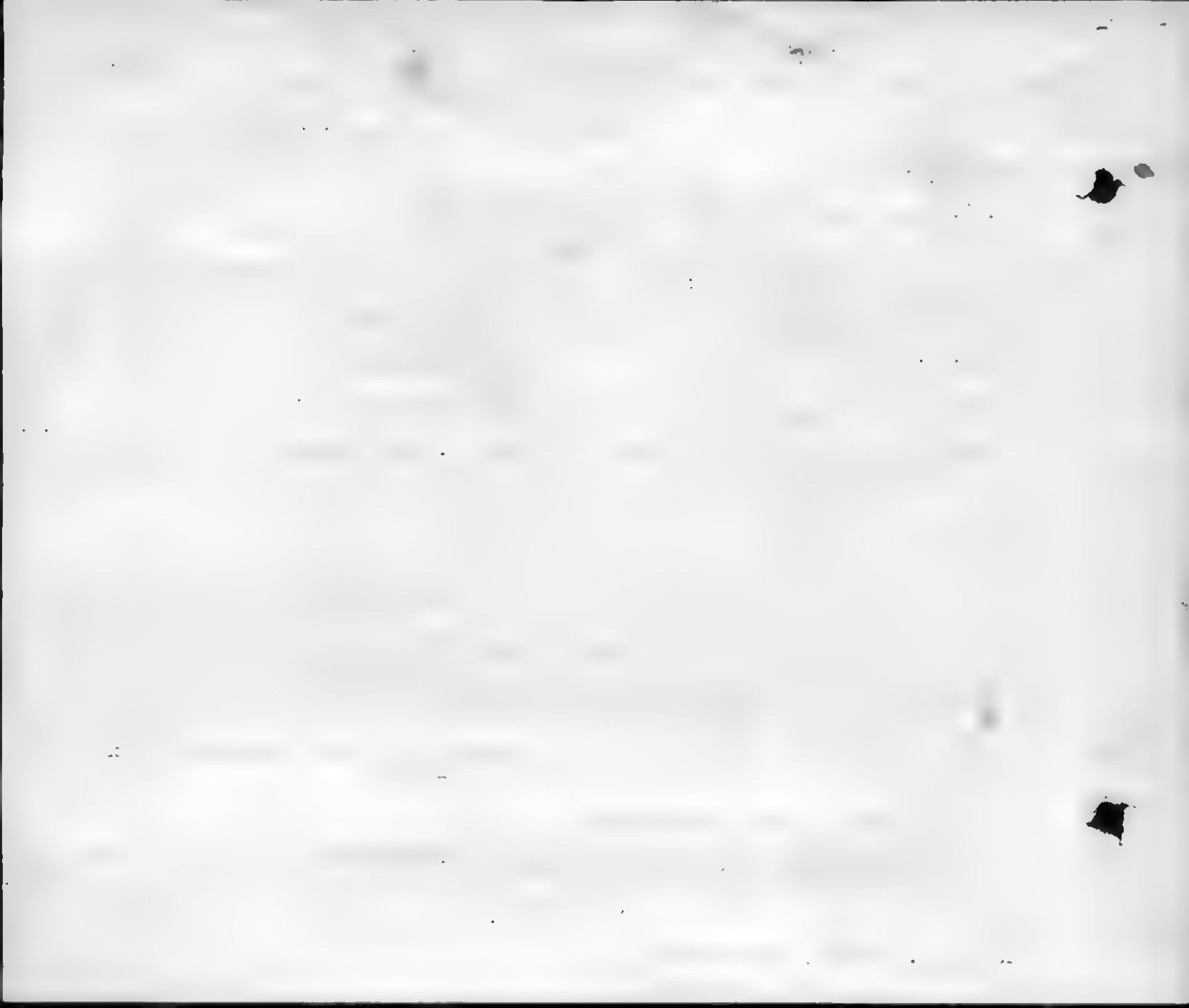
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. LENGTH OF STAY IN 1b 48 days		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE M.D.C.		b. COUNTY D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital, Bethesda, Maryland		e. STREET ADDRESS 4703 Dover Road		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DAVID HUNT STUART		4. DATE OF DEATH February 22 1962							
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 August 1885		9. AGE (in year, last birthday) 76 1/2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wythe County, Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Walter Stuart		14. MOTHER'S MAIDEN NAME Elizabeth St. Clair							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 577 48 4935		17. INFORMANT Mrs. Fay M. Stuart (wife) 4703 Dover Rd.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). 153.8 Carcinoma of colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (this hospital) attended the deceased from 2 February, 1962, to 22 February 1962, that (we) last saw the deceased alive on 22 February 1962, and that death occurred at 1207 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Clifford M. Herman M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) CLIFFORD M. HERMAN LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave		25a. REC'D BY REGISTRAR DATE FEB 26 '62		25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with this State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02157

02140

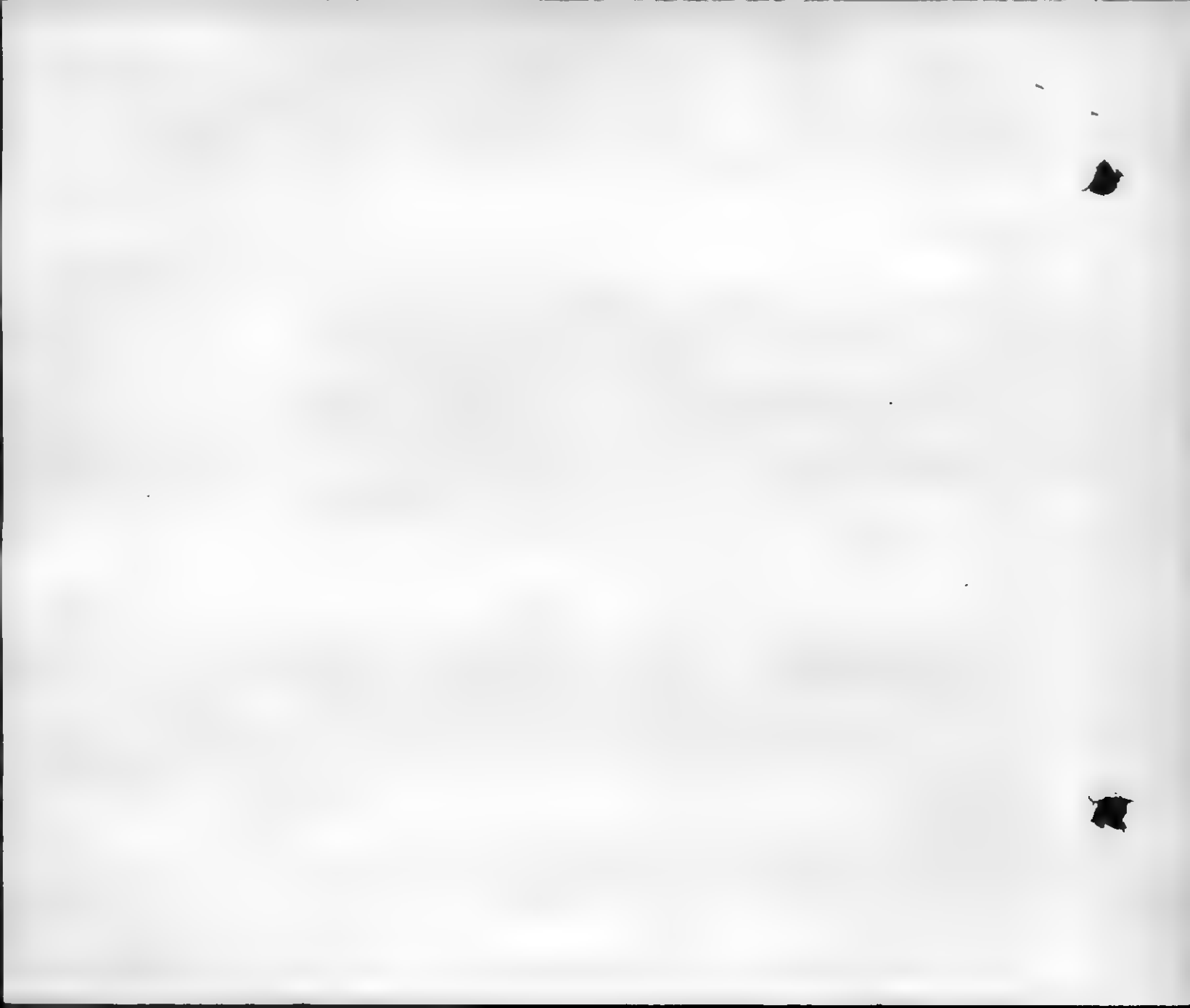
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sanitarium</u>				d. STREET ADDRESS <u>8717 Piney Branch Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Lillian</u>				4. DATE OF DEATH <u>March 6 1962</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE OF BIRTH <u>March 6 1913</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
13. FATHER'S NAME <u>Max Forest</u>				14. MOTHER'S MAIDEN NAME <u>Yetta Friedman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				17. INFORMANT <u>Tach Sussman</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUPLICATE DUPLICATE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Malignant hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... 2/13, 1962 to... 2/14, 1962 that (I) (we) last saw the deceased alive on... 2/14, 1962, and that death occurred at... 7:15 P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Mildred G. Edelman</u>				22b. DATE SIGNED <u>2/14/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>MILDRED G. EIDELMAN-M.D.</u>				22d. ADDRESS <u>1602-DILSTON RD S.S. MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>BURIAL</u>		<u>2-16-62</u>		<u>MT. MORIAH CEMETERY</u>		<u>FAIRVIEW N.J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY & SONS - 3501-14th ST NW</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 16 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>But & Frank</u>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02158
CERTIFICATE OF DEATH

Reg. Dist. 02141

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le Deau Napping Home</u>				d. STREET ADDRESS <u>4513 Harling Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Carrie First</u> Middle <u>Sutton</u> Last <u>Sutton</u>				4. DATE OF DEATH <u>Feb</u> Month <u>27</u> Day <u>1962</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 31, 1882</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>8</u>		IF UNDER 24 HRS Hours <u>20</u> Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John H. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Francis Maddox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Marie Garadi-daughter-same 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>192x</u> DUE TO <u>malignant melanoma of the left eye with metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>-----</u> (c) DUE TO <u>-----</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 7.</u> Month <u>19</u> Day <u>19</u> Year <u>1962</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 21</u> , 19 <u>59</u> , to <u>Feb 27</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Feb 12</u> , 19 <u>62</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u>			
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>				DATE SIGNED <u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemerery</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>Apr 2 '62</u>	
				24b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
 15M 7'61

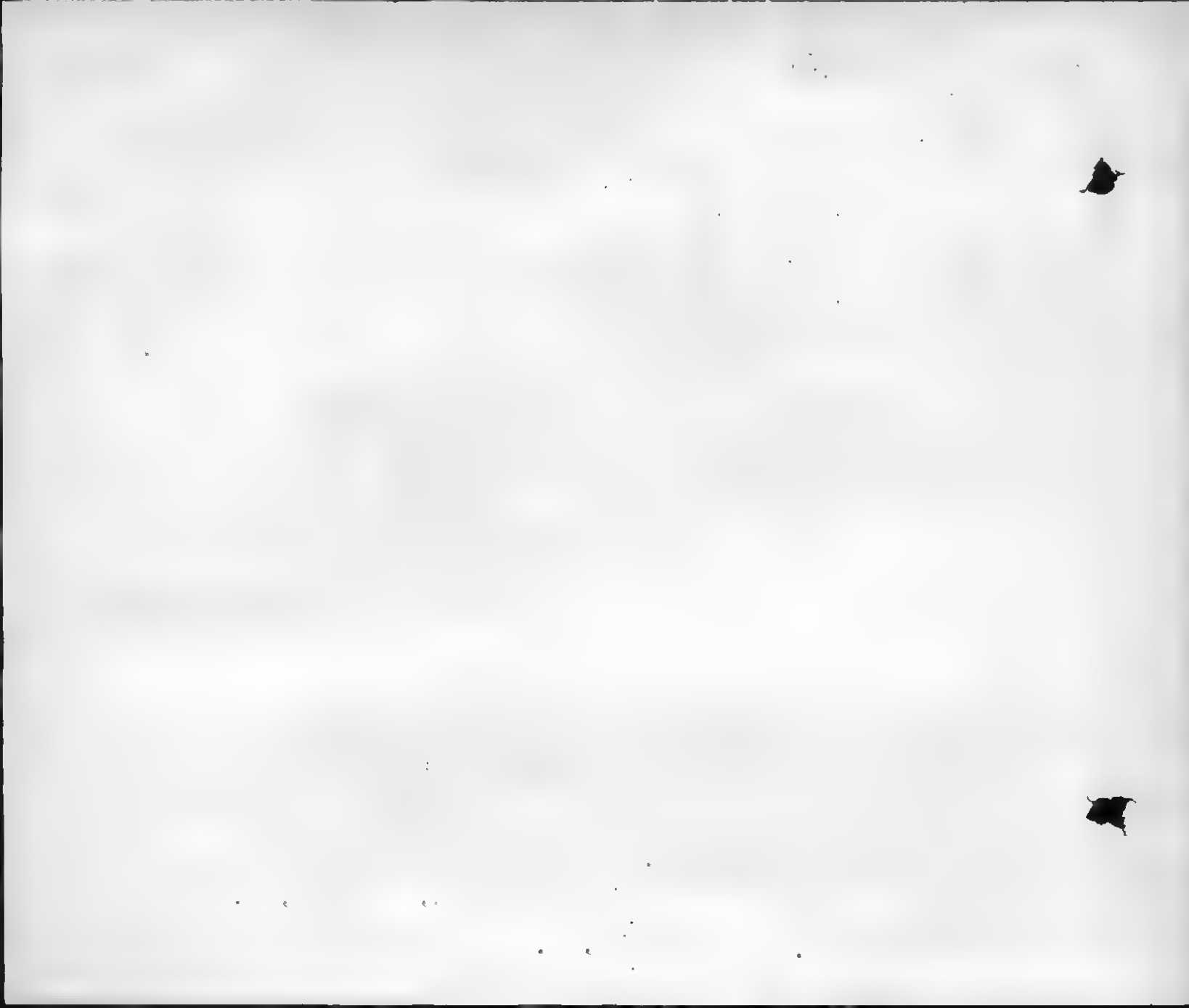
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02159

02142

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MONTGOMERY GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u> d. STREET ADDRESS _____	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HAZEL</u> Middle <u>ELIZABETH</u> Last <u>SWANN</u>		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-8-16</u>	
9. AGE (In years, if UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <u>45</u> yrs. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>			
13. FATHER'S NAME <u>WILLIAM GAINES</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET BROWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Shutdown - Nephrosclerosis</u> (b) <u>Severe Arteriosclerotic Heart Disease</u> (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>Aortic Stenosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c): _____			
INTERVAL BETWEEN ONSET AND DEATH <u>3-4 yrs.</u> <u>3-4 yrs.</u> <u>years.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____			
20c. TIME OF INJURY Month, Day, Year Hour _____ a.m. _____ p.m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1-15-62</u> <u>1955</u> <u>3:40A</u> <u>1962</u> <u>to</u> <u>2-19-62</u> <u>1962</u> <u>That (I) (we) last saw the deceased alive on</u> <u>1-15-62</u> <u>and that death occurred at</u> <u>3:40A</u> <u>M.</u> <u>from the causes and on the date stated above.</u>			
22a. SIGNATURE <u>Richard A. Yates</u>		22b. DATE SIGNED <u>2-19-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD A. YATES, M.D.</u>		22d. ADDRESS <u>OLNEY, MARYLAND</u>	
23a. BURIAL, CREMATION, REBURY (Specify) <u>2/22/62</u>		23b. DATE THEREOF _____	
23c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park.,</u>		23d. LOCATION (City, town or county) <u>Laurel, Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>FEB 21 1962</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>		25c. ADDRESS <u>Rockville, Md.</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

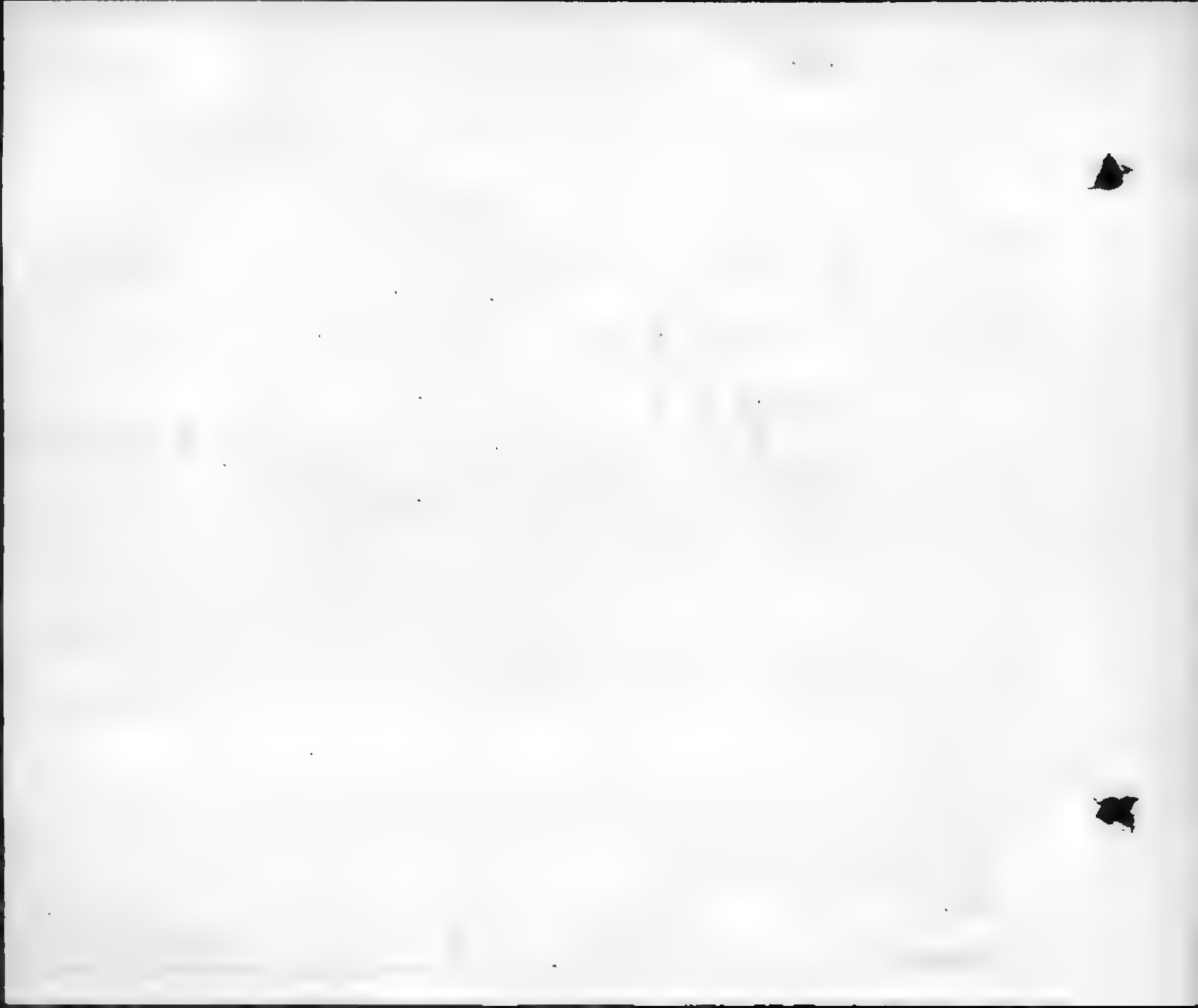
Reg. Dist. No. **02143**

02160

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sakons Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) Cedar Haven Rest Home		d. STREET ADDRESS 1343 Irving St. NW	
3. NAME OF DECEASED (Type or print) MARY EMMA First MOLTZ Middle SWANN Last		4. DATE OF DEATH Feb. 13 1962 Month Feb. Day 13 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1869
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eng. engraving		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Moltz		14. MOTHER'S MAIDEN NAME Eliza Leach	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Charles A. Swann Address 309 Riley N. Falls Church, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-1 Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) cardio vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 da 3 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1945 to Feb. 13, 1962 that I last saw the deceased alive on Feb. 13, 1962 , and that death occurred at 11:00 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE E.F. Quayle		ADDRESS (Street, city or town, state) 1822 Baltimore St. NW DATE SIGNED 2-13-62	
PHYSICIAN'S NAME (Type) E.F. Quayle		Washington D.C.	
22a. BURIAL, CREMATON, REMOVAL (Specify)	22b. DATE THEREOF Feb. 16, 1962	22c. NAME OF CEMETERY OR CREMATORY Greenmont Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John H. Walters ADDRESS 254 Carroll N.W. DC		24a. REC'D BY REGISTRAR FEB 16 '62 DATE 24b. REGISTRAR'S SIGNATURE in S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02161

CERTIFICATE OF DEATH

02144

1. PLACE OF DEATH a. <u>Rooming</u> <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<u>Wheaton Nursing Home, Wheaton, Md.</u>		<u>1302 Caddington Ave.</u>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>Sarah</u> Middle <u>-</u> Last <u>Tansky</u>		Month <u>FEB</u> - Day <u>19</u> - Year <u>1962</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/92</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Konansky</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>one</u>	
17. INFORMANT <u>Leo Tansky</u>		Address <u>1302 Caddington Ave., Wheaton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>Thecal Cell Carcinoma of Ovary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 1</u> 19 <u>61</u> to <u>Feb. 18</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Feb. 18</u> 19 <u>62</u> , and that death occurred at <u>2:25 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William Frank</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM FRANK, M.D.</u>		22d. ADDRESS <u>544 W. MONTGOMERY, ROCKVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 20, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Hebron Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Flushing, L.T., .Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Stefan...</u>		25a. REC'D BY REGISTRAR <u>4217 9th St. N.W.</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>FEB 20 1962</u>	

Stefan...



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington San + Hospital

3. NAME OF DECEASED (Type or print) Kimberly Gaye Teketch
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None

13. FATHER'S NAME James Edward Teketch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
16. SOCIAL SECURITY NO. NONE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 475X Asphyxia
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Upper Respiratory Infection
(e), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschant
EXAMINER'S NAME (Type) FRANK J. Broschant

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2-19-62
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery

23. FUNERAL DIRECTOR Raymond A. Ziska
Warner E. Humphrey, Inc. Silver Spring, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02162 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02145

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs

d. STREET ADDRESS 13217 Andrew Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

4. DATE OF DEATH Month 2 Day 15 Year 1962

9. AGE (In years last birthday) 12-6-1960
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

11. BIRTHPLACE (State or foreign country) Takoma Park, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

14. MOTHER'S MAIDEN NAME Dorothy Smith

17. INFORMANT Address James E. Teketch 13,217 Andrew Dr. Silver Spring Md.

INTERVAL BETWEEN ONSET AND DEATH sudden
2 days

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

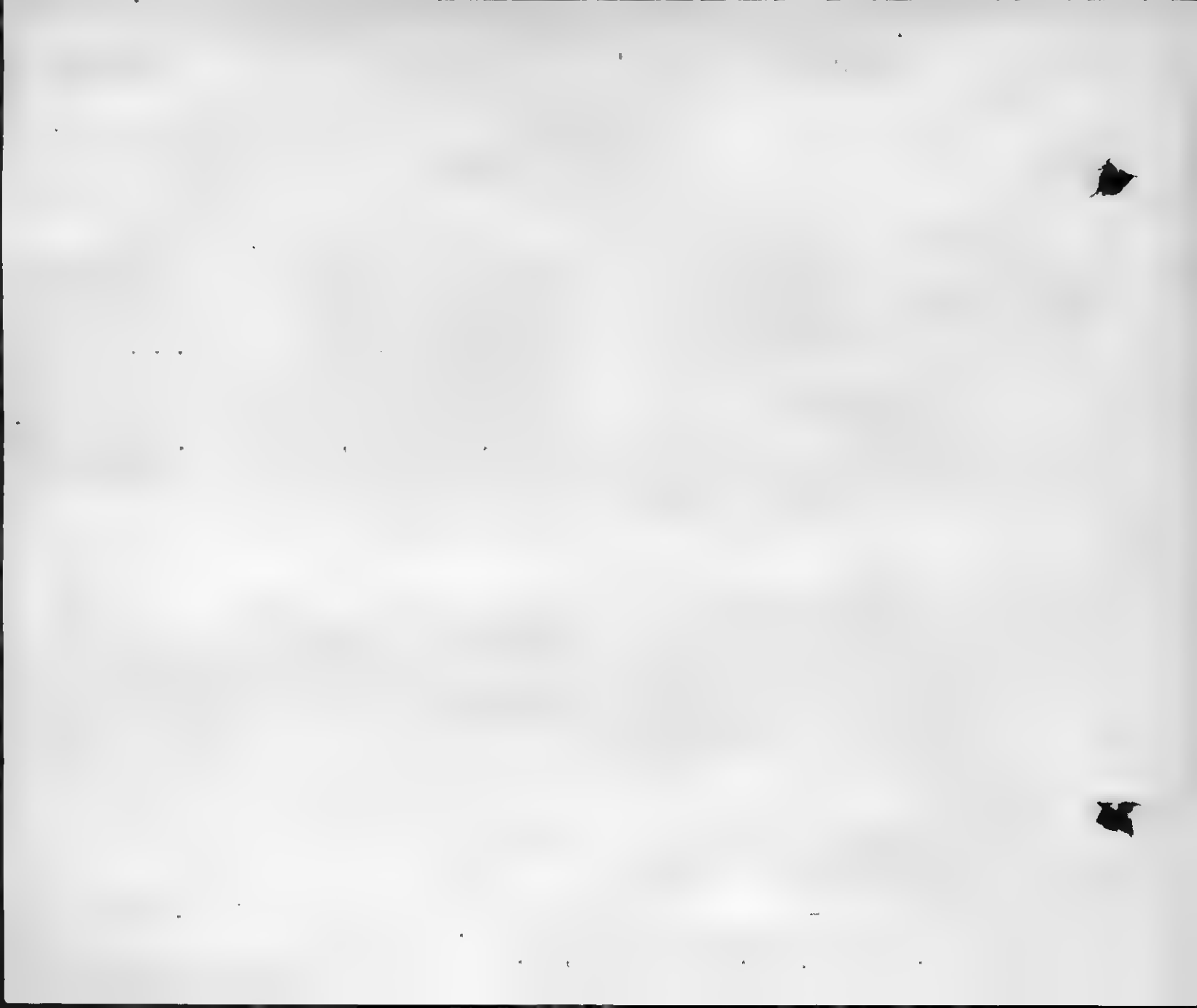
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 2-15-62
Address (Street city town or county)

22d. LOCAT ON (City, town, or country) (State)

24a. REC'D BY REGISTRAR FEB 21 '62
24b. REGISTRAR'S SIGNATURE Robert L. Knaus



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

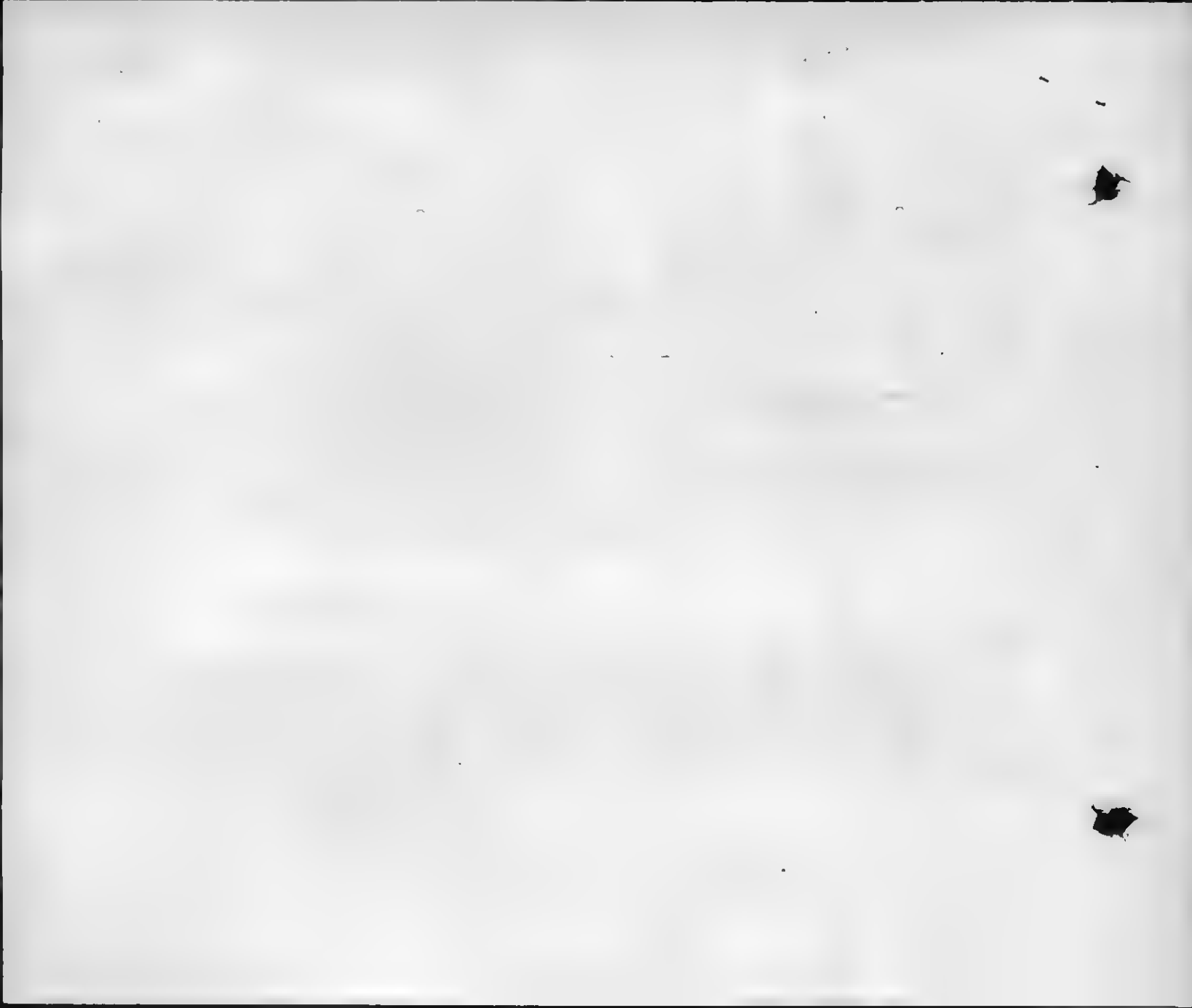
02146

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>7737 Bradley Blvd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7737 Bradley Blvd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Monica</u>				4. DATE OF DEATH <u>February 21, 1962</u>			
5. SEX <u>Female</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>1/13/62</u>			
9. AGE (In years last birthday) <u>1</u> yrs. <u>8</u> months <u>8</u> days				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Siegfried K. Temp</u>			
14. MOTHER'S MAIDEN NAME <u>Margot Huberti</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Siegfried Temp-father-same above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Confluent Bronchial Pneumonia</u> 4-11-X DUE TO (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH found dead in bed</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/23/62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAR 1 '62</u>			
24b. REGISTRAR'S SIGNATURE <u>C. L. S. Thomas</u>				DATE <u>February 21, 1962</u>			

MEDICAL CERTIFICATION

VS. A15ME
5M 9/60

74263155



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02164

02147

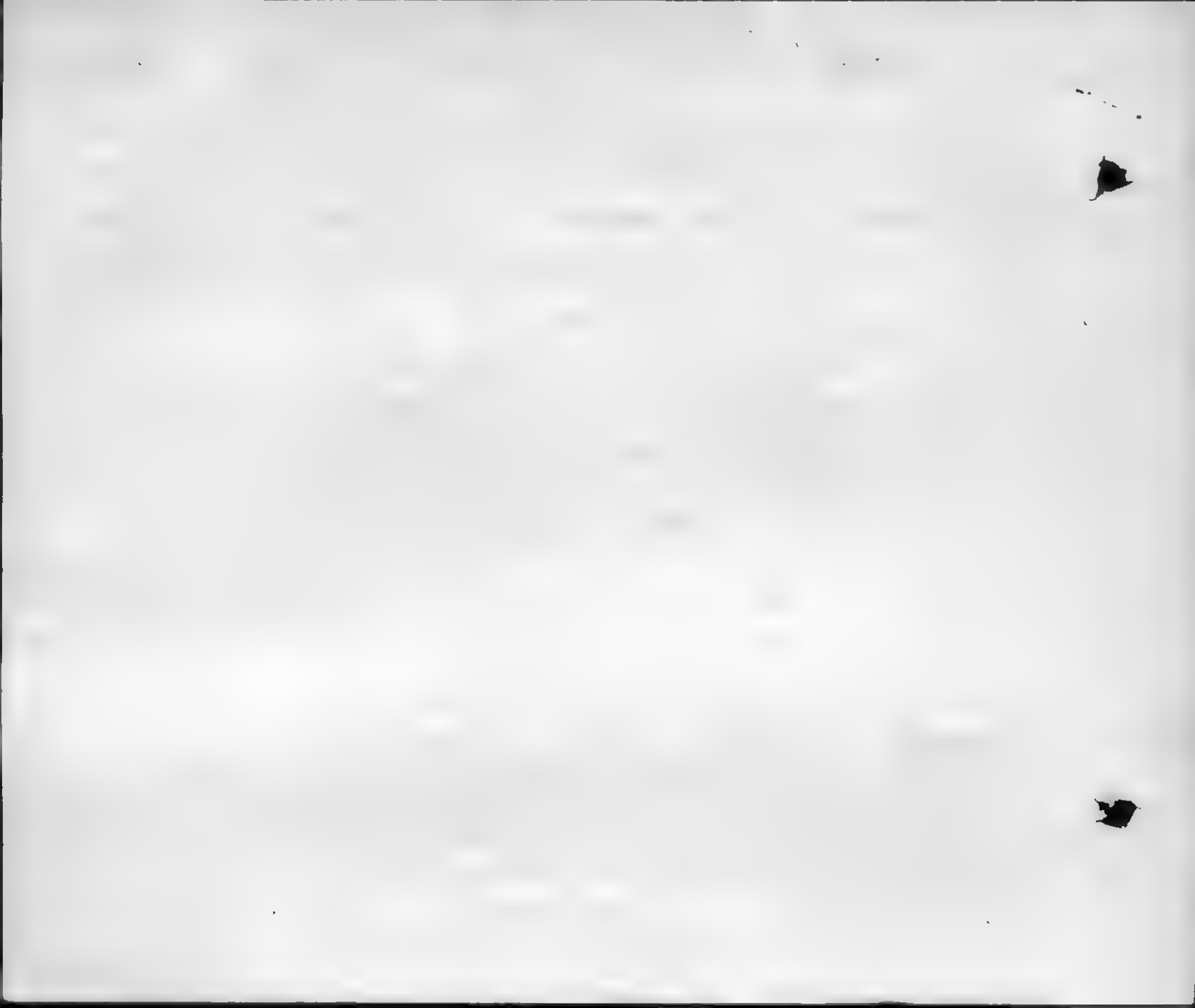
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN lb 7HR. 55MIN. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) FLEMING TERRY First Middle Last				4. DATE OF DEATH Month 2 Day 19 Year 62											
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8-5-06		9. AGE (In years last birthday) 55 yrs. If UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME EDDIE TERRY				14. MOTHER'S MAIDEN NAME LULA TERRY				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT _____ Address _____			
HOSPITAL RECORDS															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pericarditis DUE TO 526 Conditions, if any, which gave rise to immediate cause (b) Lobar Pneumonia (a), stating the underlying cause last. } DUE TO Chronic Bilateral Bronchiectasis. (c)												INTERVAL BETWEEN ONSET AND DEATH 4-6 days. 4-6 days. years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) _____												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from Oct 1:25A 1961 to Feb 1962 that (I) (we) last saw the deceased alive on 2-18-62 19 and that death occurred at 1:25A M , from the causes and on the date stated above.															
22a. SIGNATURE Richard A. Yates, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED _____							
22c. PHYSICIAN'S NAME (Type) RICHARD A. YATES, M.D.				22d. ADDRESS OLNEY, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify) 2-23-62				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY Ash Memorial.				23d. LOCATION (City, town or county) Sandy Spring, Md. (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.				25a. REC'D BY REGISTRAR DATE FEB 21 '62				25b. REGISTRAR'S SIGNATURE _____			

M

3

1





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, parts 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Parts 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

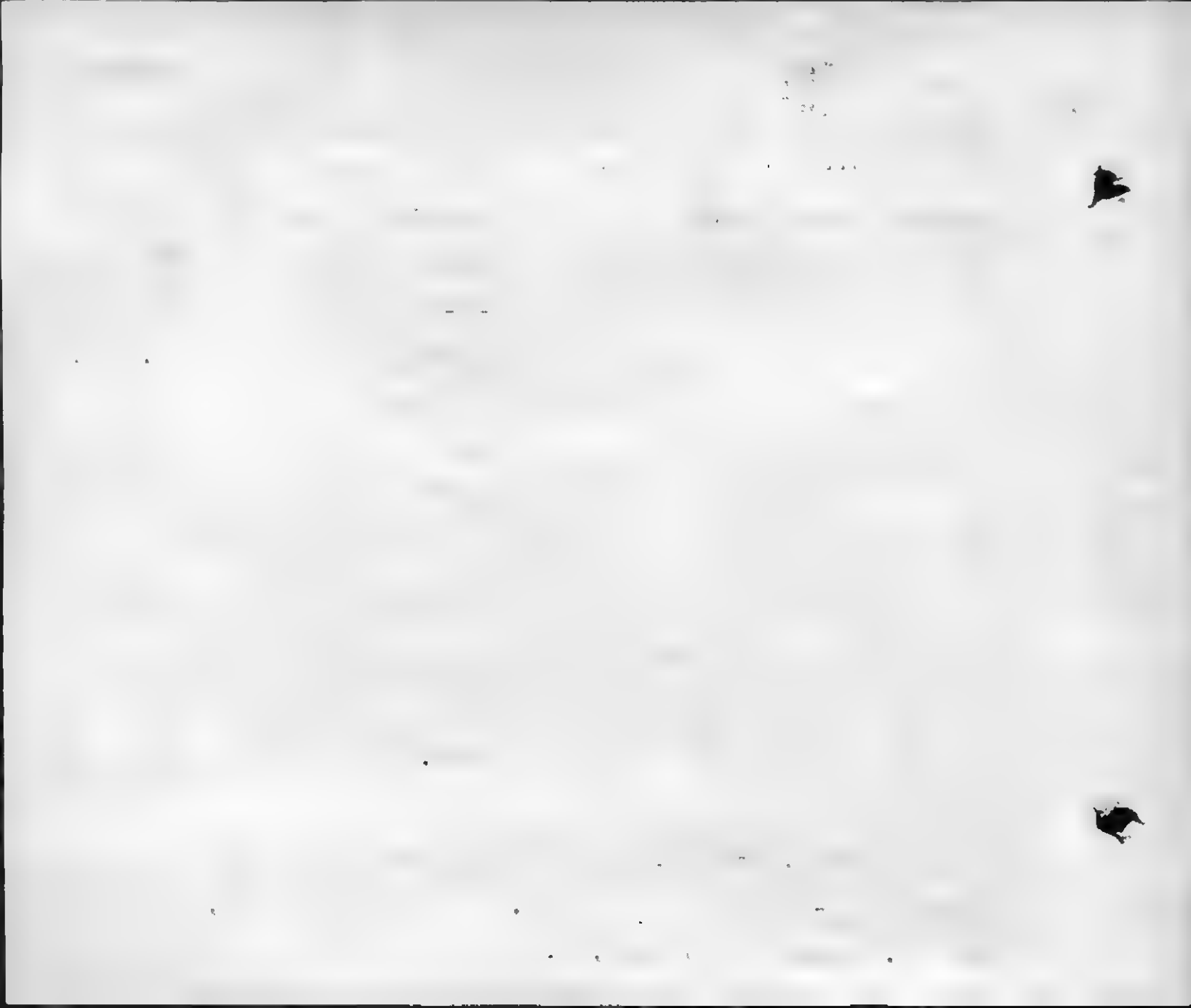
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02166

02149

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u> c. LENGTH OF STAY IN 1b <u>15 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MONTGOMERY GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>Box 273 Good Hope Road</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES ROBERT THOMAS</u> First Middle Last		4. DATE OF DEATH <u>2 22 19 62</u> Month Day Year	
5. SEX <u>MALE</u> <u>COLORED</u> 6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-14-81</u> 9. AGE (In years last birthday) <u>80</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>SARAH MOSBY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>HOSPITAL RECORDS</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY Emboli</u> DUE TO (b) <u>VARICOSE VEINS (LEG bilateral)</u> (c) <u>HYPERTENSIVE HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) did not attended the deceased from <u>January 1961</u> to <u>2/22</u>, 1962 that (I) yes last saw the deceased alive on <u>2/22</u>, 1962 and that death occurred at <u>8:40A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John P. Martin</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN P. MARTIN, M.D.</u>		22b. DATE SIGNED 22d. ADDRESS <u>SANDY SPRING, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-26-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Round Oak Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Spencerville, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> 24b. ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>(S) S. Kraus</u>	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02167		02150	
1. PLACE OF DEATH a. COUNTY Nontgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg c. LENGTH OF STAY IN 1b 6 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for Aged Inc		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella d. STREET ADDRESS X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last TICE		4. DATE OF DEATH Month Feb Day 19 Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1868
9. AGE (In years last birthday) 93 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) packing & shipping		10b. KIND OF BUSINESS OR INDUSTRY Phillips Bros. Balto	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Henry Tice		14. MOTHER'S MAIDEN NAME Eliza Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO 212 20 7081	
17. INFORMANT records of Asbury Home, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 720 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Several years Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-10, 1960 to 2-19, 1962 , that (I) (we) last saw the deceased alive on 2-18, 1962 and that death occurred at 10:45 PM from the causes and on the date stated above.			
22a. SIGNATURE James W. Egan M D		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James W. Egan		22d. ADDRESS 7720 Wisconsin Ave - Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-22-1962	
23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION (City, town, or county) (State) Ellicott City, Md	
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham ADDRESS Ellicott City, Md		25a. REC'D BY REGISTRAR Feb 21 '62	
		25b. REGISTRAR'S SIGNATURE Richard S. Gorman	

11

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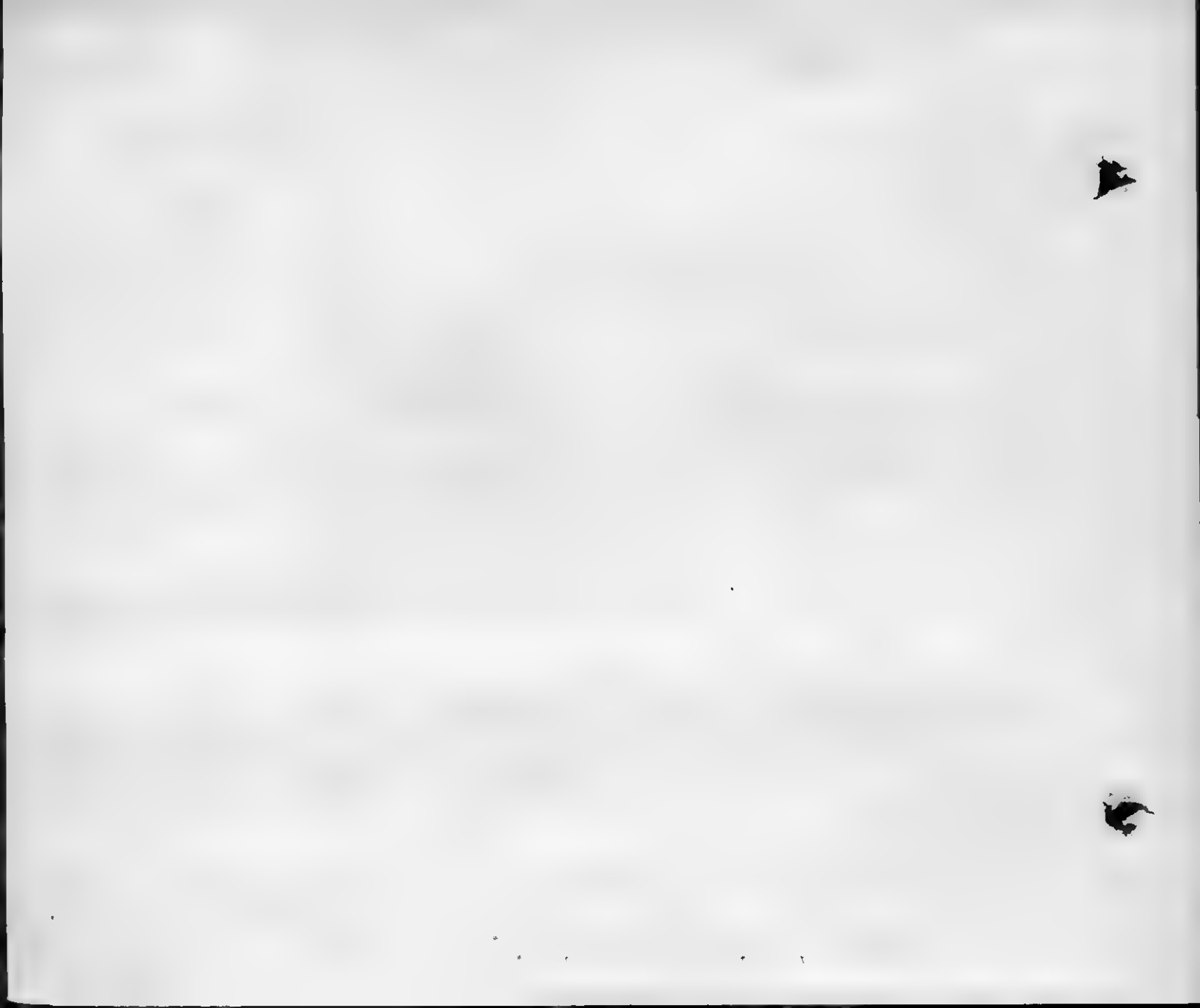


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
c. LENGTH OF STAY in 1b <u>12 yrs</u>						d. STREET ADDRESS <u>9832 Capital View Cir</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9832 Capital View Cir</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>James Henry Tillson</u>						4. DATE OF DEATH <u>Feb 3 1962</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 29, 1899</u>		9. AGE (In years last birthday) <u>62 yrs</u>		IF UNDER 1 YEAR: Months <u>0</u> Days <u>3</u> IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>					
11. BIRTHPLACE (State or foreign country) <u>Mass</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Tillson</u>						14. MOTHER'S MAIDEN NAME <u>unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give year or dates of service) <u>WW I & II</u>						16. SOCIAL SECURITY NO. <u>YES</u>					
17. INFORMANT <u>Albert Anderson - Stem</u>						Address <u>Stem</u>					
18. CAUSE OF DEATH (Enter only one cause for I, a, for (e), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>3rd degree burn involving entire body -</u>											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>body -</u>											
(c) <u>House fire</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>House fire at home -</u>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>4:30 p.m. 2-3 1962</u>											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>											
20f. (City or town) <u>Silver Spring monty md</u> (County) <u>md</u> (State) <u>md</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-3-62</u>											
Address (Street, city, town, or country)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>2-7-62</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>											
22d. LOCATION (City, town, or country) <u>Suitland Prince Georges Co Md.</u>											
23. FUNERAL DIRECTOR <u>Raymond Q. Ziska</u> 8434 ADDRESS <u>Georgia Ave.</u>											
24a. REC'D BY REGISTRAR <u>Feb 7 '62</u> 24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>											
DATE											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

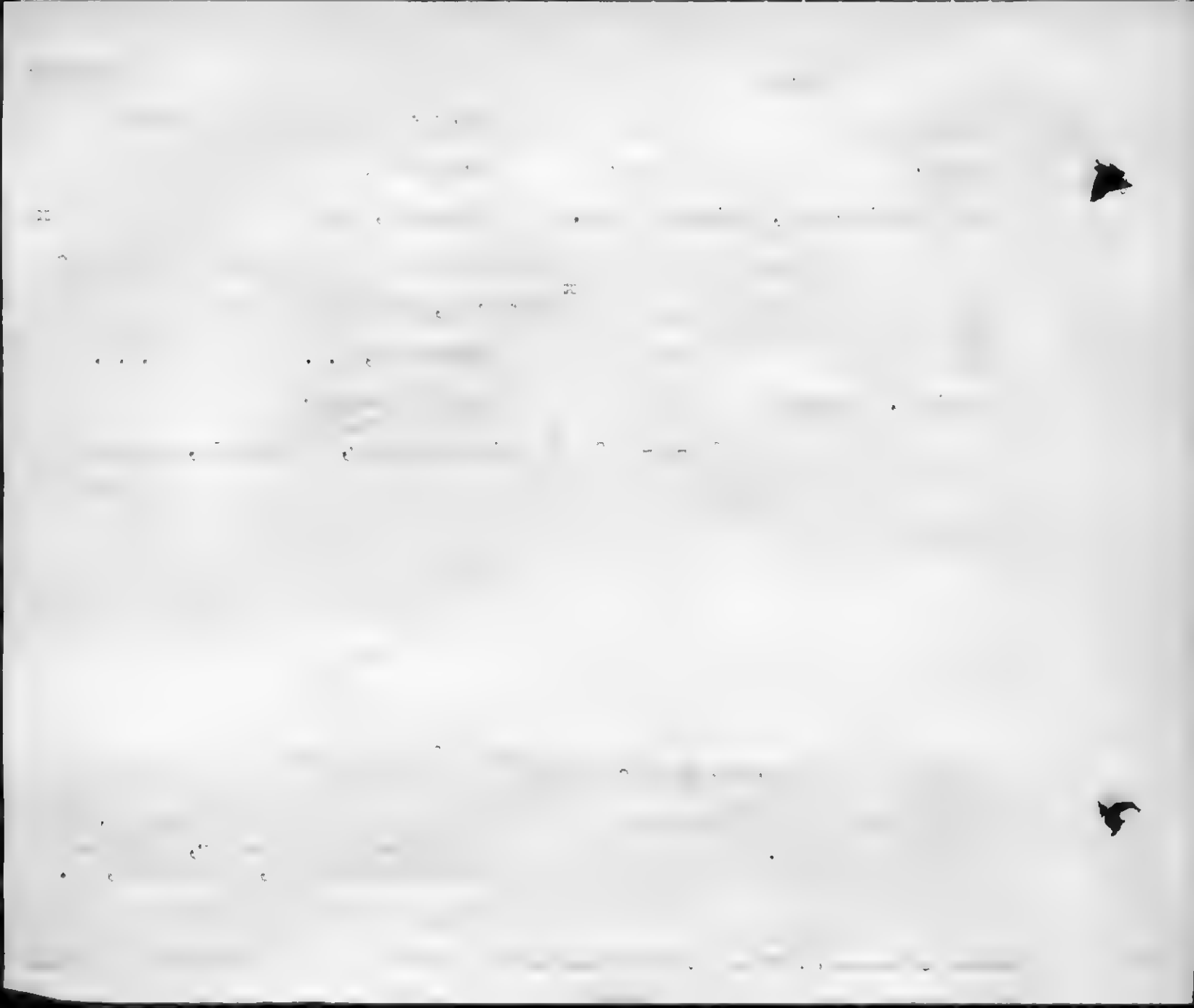
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02169

02152

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY N 1b 76 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Vienna c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Great Falls d. STREET ADDRESS Route # 1, Box 195	
3. NAME OF DECEASED (Type or print) James Chester Tinkham		4. DATE OF DEATH Month February Day 14 Year 19 62	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> February 3, 1944		8. DATE OF BIRTH 18 yrs. February 3, 1944	
9a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Student		9b. KIND OF BUSINESS OR INDUSTRY None	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis C. Tinkham		14. MOTHER'S MAIDEN NAME Luella Schreiner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT 228-54-5212 The Medical Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reticulum cell Sarcoma, generalized DUE TO (b) 20 DUE TO (c) 20 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 30, 1961 to February 14, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 14, 1962 , and that death occurred at 4:00 AM from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Henderson M.D.		22b. DATE SIGNED February 14, 1962	
22c. PHYSICIAN'S NAME (Type) Edward S. Henderson		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 17 1962	
23c. NAME OF CEMETERY OR CREMATORY Nat. Memor. Park		23d. LOCATION (City, town or county) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Pearson Funeral Home		25a. REC'D BY REGISTRAR FEB 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume		25c. REGISTRAR'S SIGNATURE Arthur S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

02170

02153

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

8316 Carey Lane

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Charles

Leonard

Tippett

5. SEX

Male

White

6. COLOR OR RACE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Feb 16, 1892

9. AGE (In years last birthday)

70 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Model Maker

10b. KIND OF BUSINESS OR INDUSTRY

Delaware Water-Navy Dept. Basin

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George Leonard Tippett

14. MOTHER'S MAIDEN NAME

Mary J. Fitzgerald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

579-18-5389

17. INFORMANT

Katherine Diack Tippett 8316 Carey Lane, S.S., Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e)

Acute Coronary Insufficiency

420.1 DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

Rupture of Atheromatous Plaque

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e)

INTERVAL BETWEEN ONSET AND DEATH

sudden

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschart

M.D.

EXAMINER'S NAME (Type)

Frank J. Broschart

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

February 28, 1962

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

3-3-62

22c. NAME OF CEMETERY OR CREMATORY

Fort Lincoln Cemetery

22d. LOCATION (City, town, or country)

Prince Georges County, Maryland

23. FUNERAL DIRECTOR

Warner E. Pumphrey, Inc., Silver Spring, Md.

ADDRESS

2434 Georgia Ave

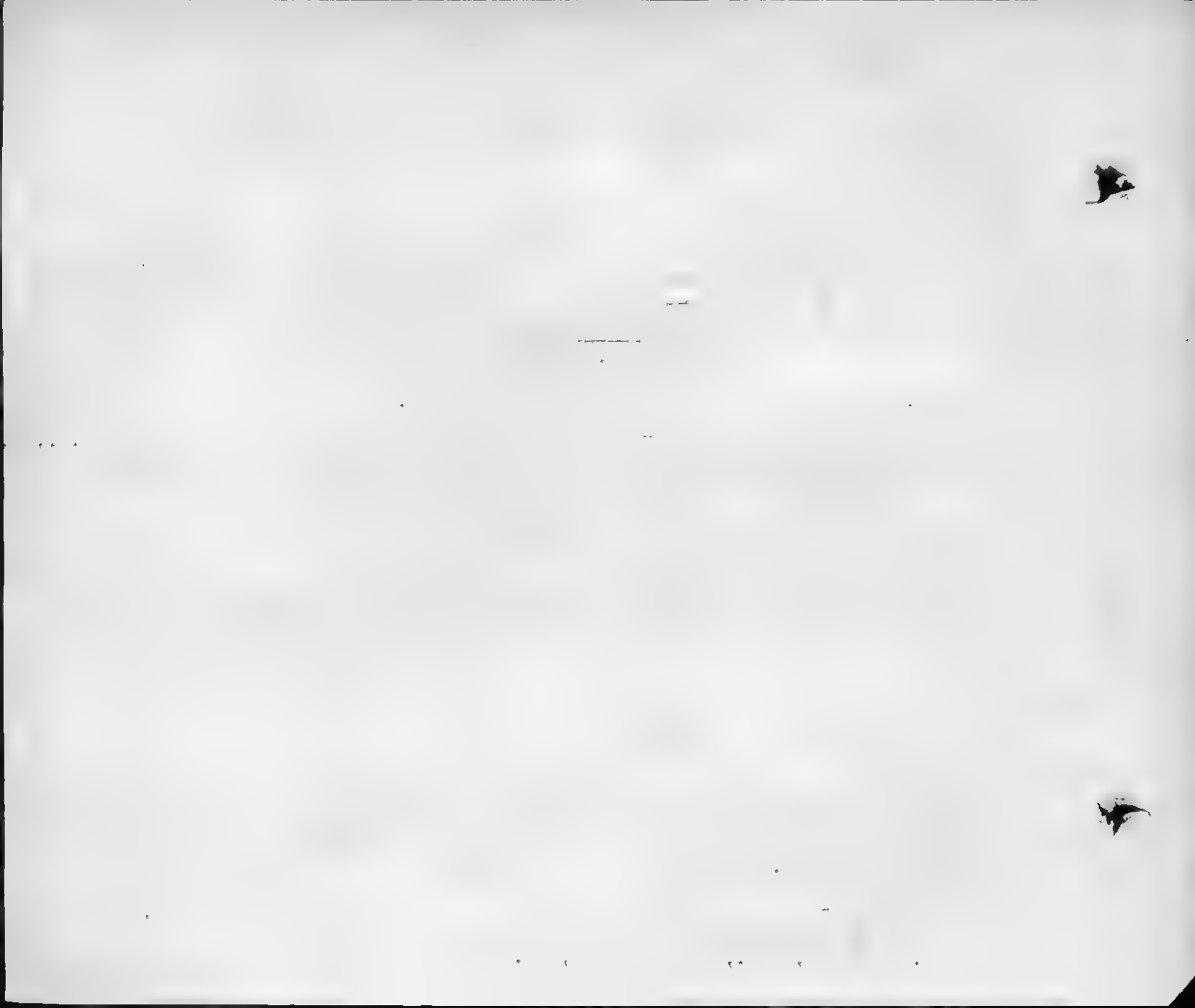
24a. REC'D BY REGISTRAR

DATE MAR 2 '62

24b. REGISTRAR'S SIGNATURE

W. E. Pumphrey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 2 and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02154

Weight 12g 02171

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RJRA and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 2 MINUTES
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RJRA and give nearest town) Rockville
d. STREET ADDRESS 4804 ASPENHILL Rd

3. NAME OF DECEASED (Type or print) BABY GIRL TITUS
4. DATE OF DEATH FEBRUARY 4 1962

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH FEBRUARY 4, 1962 9. AGE (In years last birthday) 2 yrs. 10. IF UNDER 1 YEAR 2 Months 2 Days 2 Hours 2 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FATHER 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND 11. BIRTHPLACE (County & State, or foreign country) U.S.A 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME NORMAN FRANKLIN TITUS 14. MOTHER'S MAIDEN NAME ETHEL ANN DIXON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. — 17. INFORMANT FATHER

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity 21 weeks
DUE TO (b) Premature rupture of Membrane
DUE TO (c) —

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) —

20c. TIME OF INJURY Month, Day, Year 2/4 1962 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State) —

21. I certify that (I) (this hospital) attended the deceased from 2/4 1962 to 2/4 1962 that (I) (we) last saw the deceased alive on 2/4 1962 and that death occurred at 11:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE Albert S. Bright M.D. 22b. DATE SIGNED 2/4 1962

22c. PHYSICIAN'S NAME (Type or print) ALBERT S. BRIGHT MD 22d. ADDRESS 8218 Wisconsin Ave Bethesda

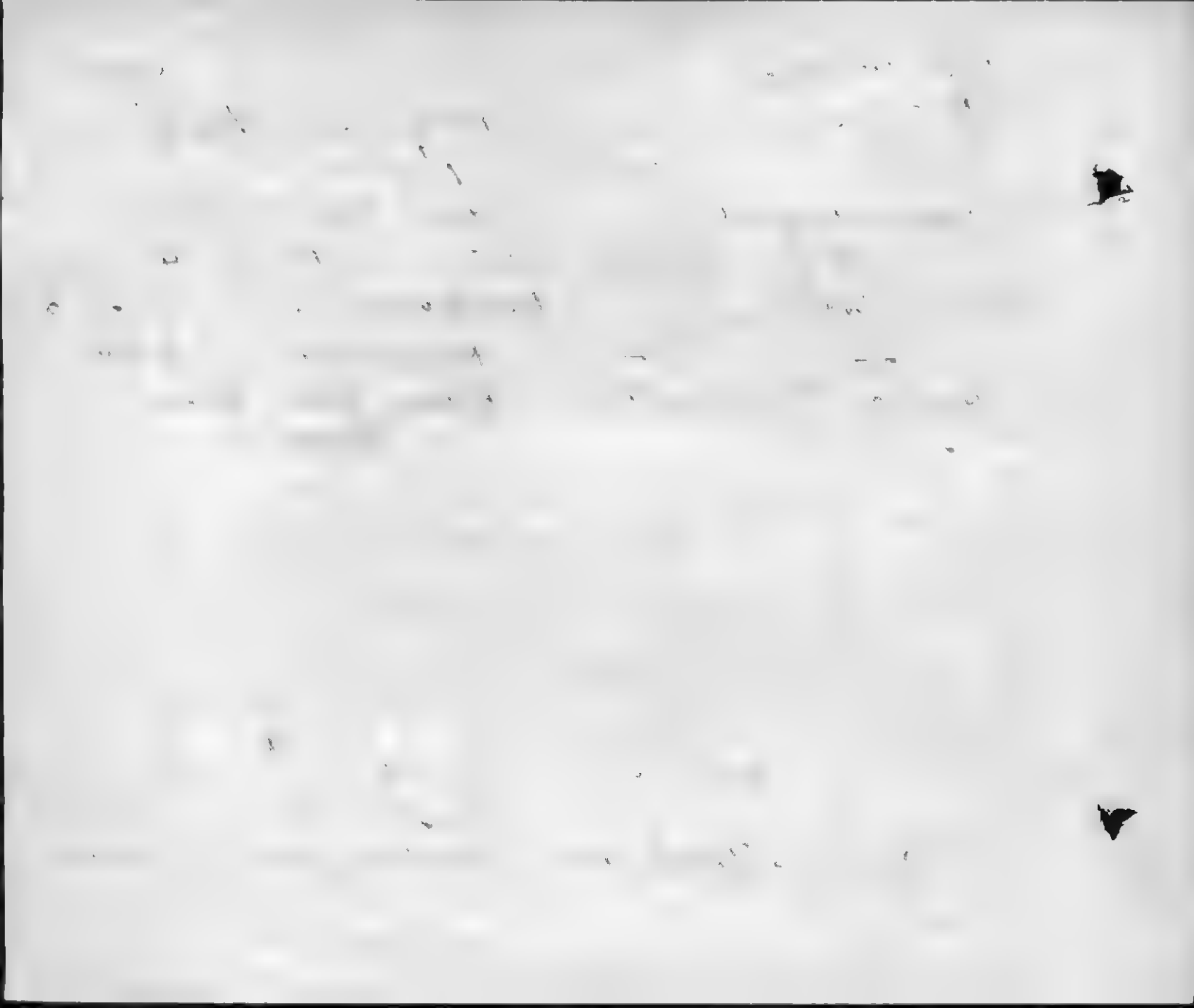
23a. BURIAL, CREMATION, 23b. DATE THEREOF 2-4-62 23c. NAME OF CEMETERY OR CREMATORY SUBURBAN HOSPITAL 23d. LOCATION (City, town or county) (State) BETHESDA, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE AMELIA CARTER ADMIN. - SUBURBAN HOSPITAL ADDRESS BETHESDA, MD. 25a. REC'D BY REGISTRAR FEB 7 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

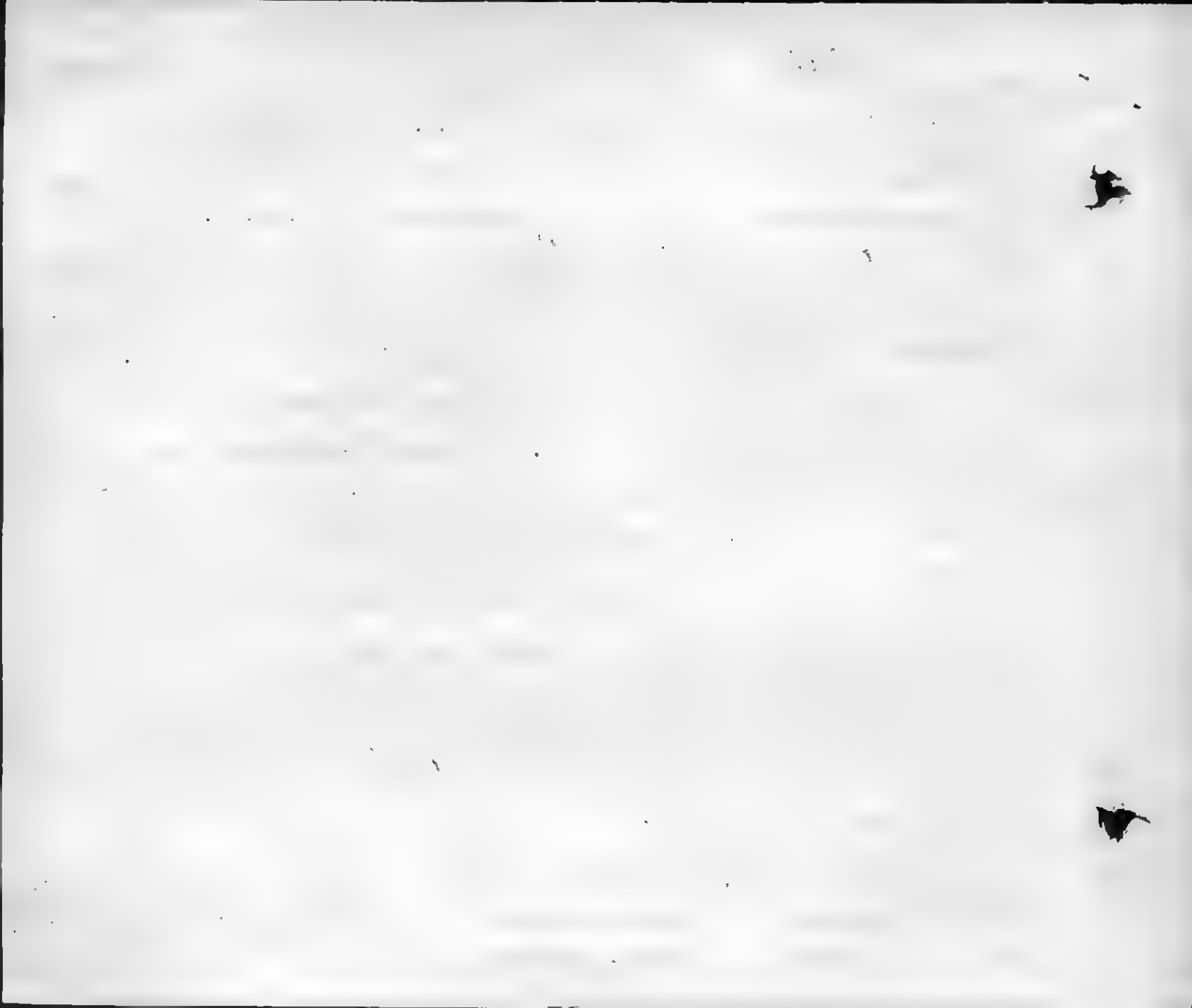
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02172

02155

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3328 Runnymede Place, N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EULA</u> Middle <u>HAILE</u> Last <u>UNDERWOOD</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>FE</u>		6. COLOR OR RACE <u>WH</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-17-84</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> IF UNDER 24 HRS. Hours <u>7</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>South Carolina</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Felix Haile</u>		14. MOTHER'S MAIDEN NAME <u>Prudence (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>Mrs. Ralph McDowell-daughter- Same</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>MYOCARDIAL INFARCTION - HEART BLOCK</u> (b) <u>CORONARY ARTERY DISEASE</u> (c) <u>ARTERIO SCLEROSIS, generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 yrs</u> <u>2 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>11:40</u> a.m. <u>March 13, 1960</u> to <u>Feb 5, 1962</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Washington Clinic, WASH. D.C.</u>	
20f. (City or town) <u>Washington</u>		20g. (County) <u>D.C.</u>	
20h. (State) <u>D.C.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>March 13, 1960</u> to <u>Feb 5, 1962</u> but (I) (we) last saw the deceased alive on <u>Feb 5, 1962</u> and that death occurred at <u>11:40</u> A.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>Robert G. Taylor</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>Feb 6, 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. TAYLOR</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 2/8/62</u>		23b. DATE THEREOF <u>2/8/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Haile Cemetery</u>		23d. LOCATION (City, town or county) <u>Jonesville, South Carolina</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 9 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Robert S. Thoms</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

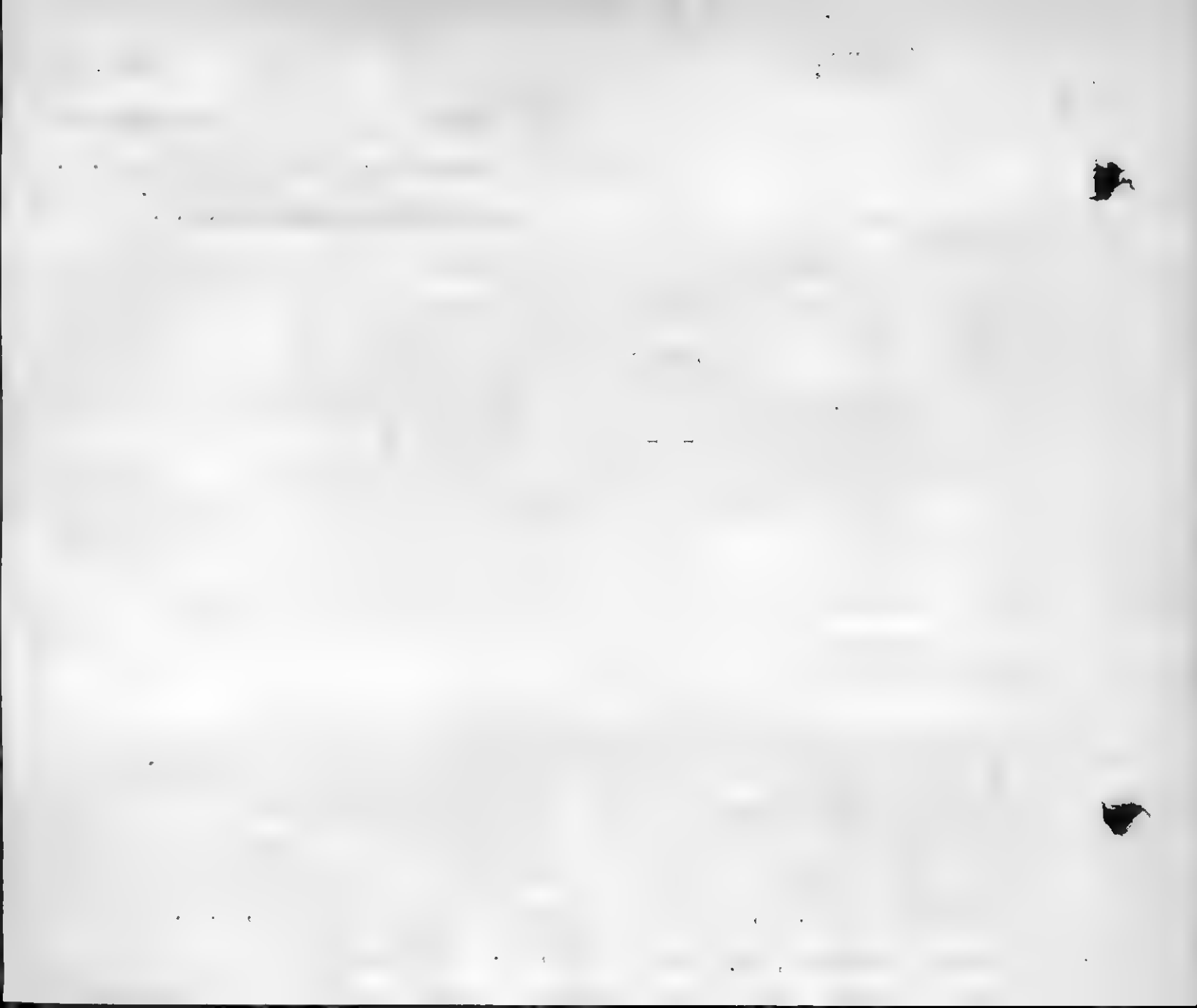
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02173

02156

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Gen. Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>5130 Connecticut Ave., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Dr. Arthur Thomas Utz</u>		4. DATE OF DEATH Last <u>Utz</u> Month <u>2</u> Day <u>25</u> Year <u>1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-13-75</u>		9. AGE (in years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>David E. Utz</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Myers</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>579-52-3902A</u>				17. INFORMANT <u>Hospital Records</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>5-8</u> DUE TO <u>Influenza pneumonia followed by embolization for gallstones & infection</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>																							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>											
21. I certify that (I) (this hospital) attended the deceased from <u>2-7</u> <u>1962</u> to <u>2-25</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>2-24</u> <u>1962</u> , and that death occurred about <u>8:00</u> A.M. from the causes and on the date stated above.																							
22a. SIGNATURE <u>Chas H. Wolcott</u>				22b. DATE SIGNED <u>2/25/62</u>				22c. PHYSICIAN'S NAME (Type) <u>Chas H. Wolcott</u>				22d. ADDRESS <u>7607 Carroll Ave</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb. 28, 1962</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pamphrey, Inc.</u>																25a. REC'D BY REGISTRAR <u>1 '62</u>				25b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

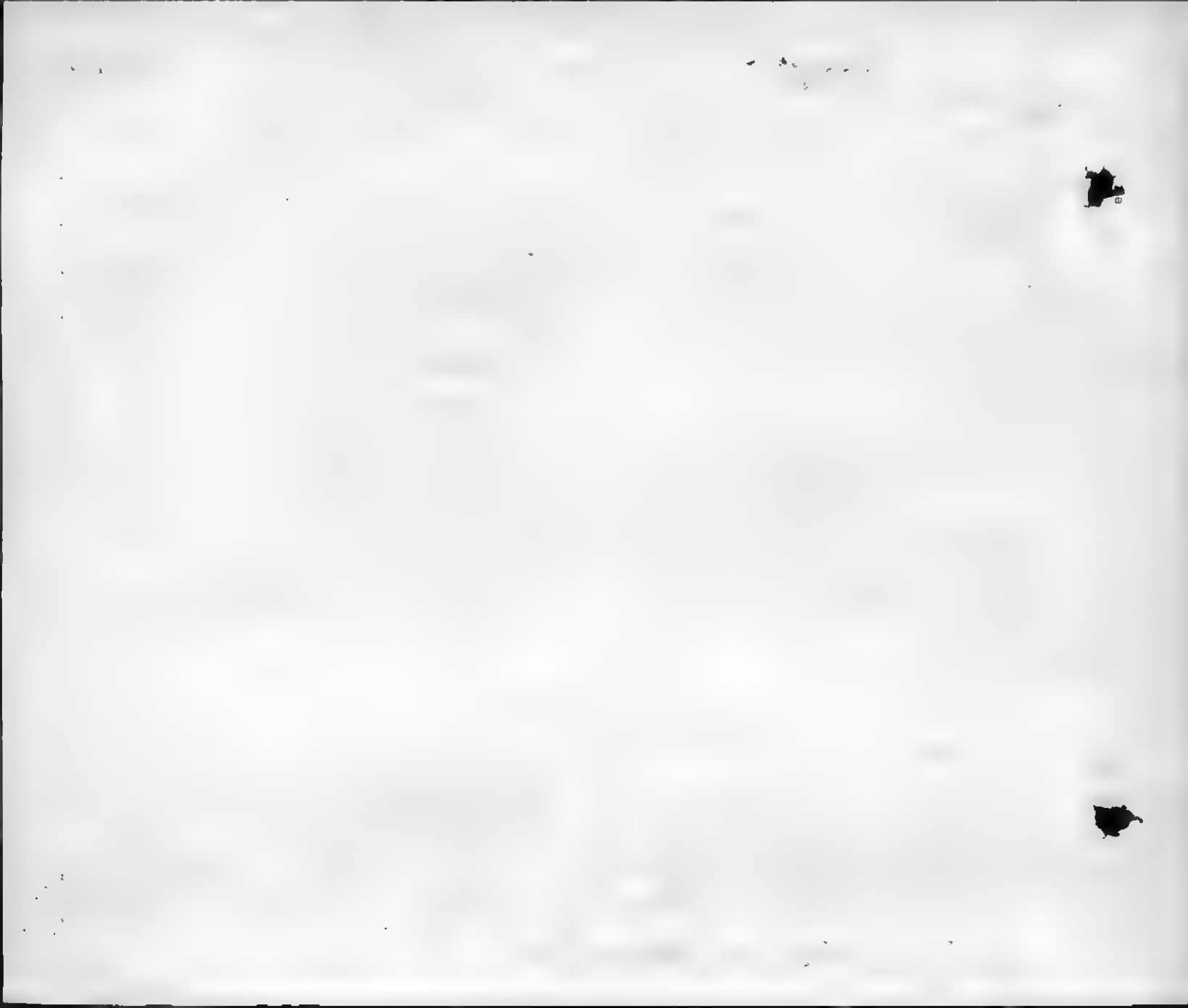
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02174

02157

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>13 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>605 Philadelphia Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Emmett Guy Vannoy</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>15</u> - Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-95</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>	
11. IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Vannoy</u>		14. MOTHER'S MAIDEN NAME <u>Della Bush</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>National Guard</u>		16. SOCIAL SECURITY NO. <u>Wife</u>	
17. INFORMANT <u>same</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia & Emaciation</u> DUE TO (b) <u>metastases to bones</u> CONDITIONS, if any, which gave rise to immediate cause (c) <u>Carcinoma of Prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 months</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u> <u>6 1/2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February, 1961</u> to <u>2-15-1962</u> , that (I) (we) last saw the deceased alive on <u>2-15-1962</u> , and that death occurred <u>2-15-1962</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman C. Shoemaker, M.D.</u>		22b. DATE SIGNED <u>Feb 17 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman C. SHOEMAKER, M.D.</u>		22d. ADDRESS <u>8005 Woodbury Dr. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Feb. 17, 1962</u>		23b. DATE THEREOF <u>Feb. 17, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Prince George's Co. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Sellers</u>		24. ADDRESS <u>254 Cornell St. N.W. DC</u>	
25. REC'D BY REGISTRAR <u>DATE FEB 19 1962</u>		25. REGISTRAR'S SIGNATURE <u>C. H. F. Smith</u>	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

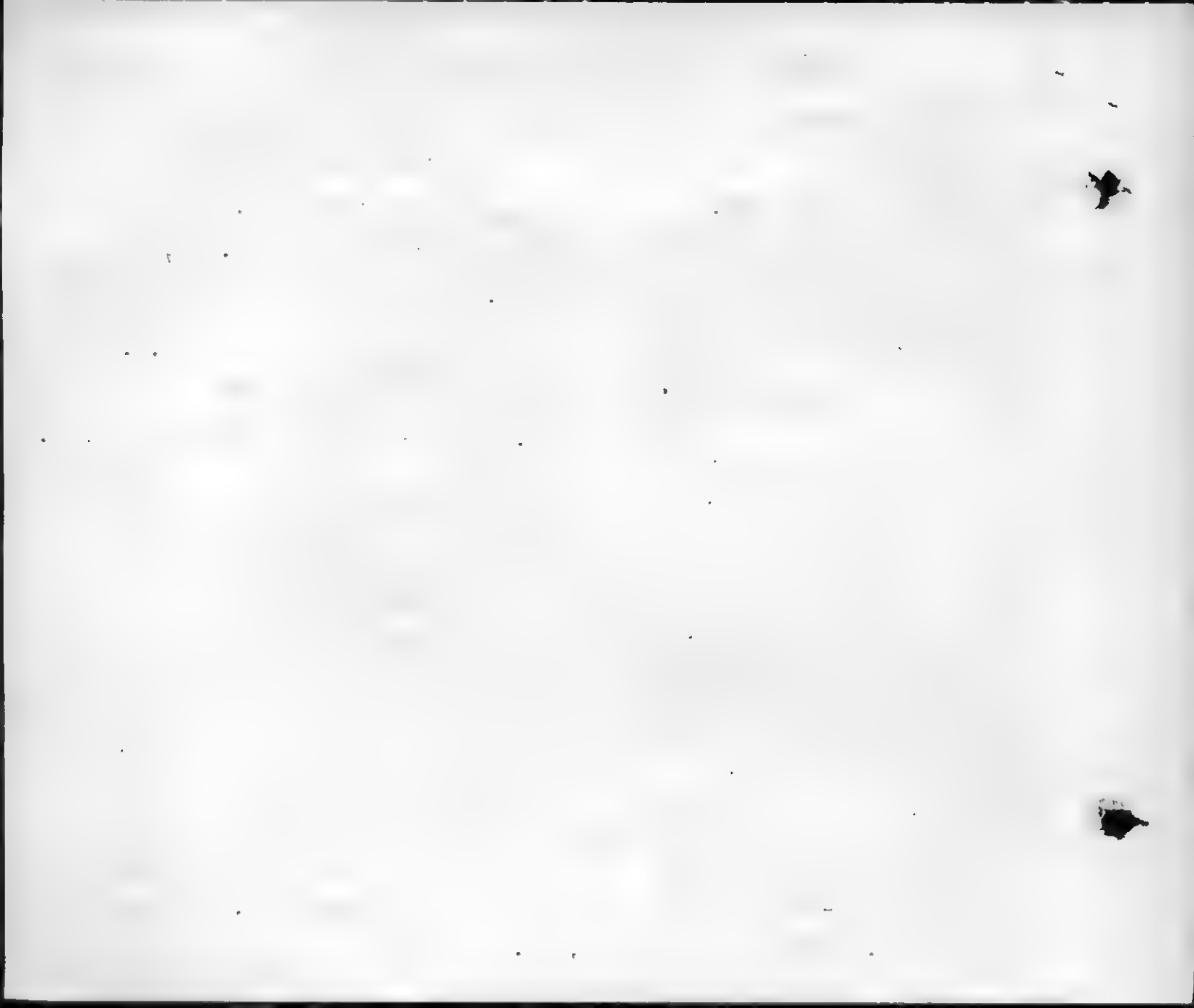
CERTIFICATE OF DEATH

02175

02158

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10937 Montrose Ave.		d. STREET ADDRESS 10937 Montrose Ave.	
3. NAME OF DECEASED (Type or print) First IDA Middle HOUGHTON Last VanTROTSBURG		4. DATE OF DEATH Month Feb. Day 7 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1870
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 12 Days 7 Hours 0 Min 0	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Jackson Houghton		14. MOTHER'S MAIDEN NAME Annie Elizabeth Fogg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Neice Mrs. Richard Dupree		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - Aorta DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Severity - (age 91) DUE TO Senility - (age 91) (c) Upper Respiratory Infection (f m k)			INTERVAL BETWEEN ONSET AND DEATH acute (Hx.) yrs. yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (of 18) Upper Respiratory Infection (f m k)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 1955 19 to 2/7/62 19, that (1) (we) last saw the deceased alive on 2/6/62 19, and that death occurred at 6 A.M. from the causes and on the date stated above			
22a. SIGNATURE SAM ALLEN		22b. DATE SIGNED 2/7/62	
22c. PHYSICIAN'S NAME (Type) SAM ALLEN, M.D.		22d. ADDRESS Remington, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-10-62	23c. NAME OF CEMETERY OR CREMATORY Remington Cemetery	23d. LOCATION (City, town, or county) (State) Remington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR FEB 9 '62	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE J. S. H. Allen	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 307 2-23

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02176 CERTIFICATE OF DEATH 02159

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md. b. COUNTY Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d. STREET ADDRESS 603-McIntyre Rd. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last
Kenneth C. Walters

4. DATE OF DEATH Month Day Year
Feb. 8 1962

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 5/21/24
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 37 yrs. IF UNDER 1 YEAR Months Days Hours Min. 9 6

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reduction engineer Engineering 10b. KIND OF BUSINESS OR INDUSTRY Engineering 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William R. Walters 14. MOTHER'S MARRIED NAME Martha S. Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? yes 16. SOCIAL SECURITY NO. 44-1856 17. INFORMATION Robert M. Walters, Gaithersburg, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
178X DUE TO (b) Pulmonary metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Carcinoma of testicle

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) none

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 15 to Feb 8, 1962, that (I) (we) last saw the deceased alive on Feb 8, 1962, and that death occurred at home from the causes and on the date stated above.

22a. SIGNATURE Robert A. Pumphrey M.D. 22b. DATE SIGNED Feb 13 '62

22c. PHYSICIAN'S NAME (Type) H. Killay 22d. ADDRESS 8275 Wisconsin Ave

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/10/1962 23c. NAME OF CEMETERY OR CREMATORY Parklawn 23d. LOCATION (City, town or county) (State) Rockville Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland 25a. REC'D BY REGISTRAR Feb 13 '62 25b. REGISTRAR'S SIGNATURE William S. Hanks



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 007 2-26-62

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02100

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda D.O.A.
c. LENGTH OF STAY in 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg
d. STREET ADDRESS Route # 3

3. NAME OF (Type or print) Jeffery Lynn Webb
First Middle Last
4. DATE OF DEATH Feb. 10, 1962
Month Day Year
9. AGE (In years last birthday) 3 6 62
Months Days Hours Min.

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 11/4/61
WIDOWED ☐ DIVORCED ☐
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ernest Simon Webb 14. MOTHER'S MAIDEN NAME Ila Faye Temple
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Mother same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital heart disease
754.2 DUE TO (b) Interventricular septal defect
Conditions, if any, which gave rise to immediate cause (c)
(e), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Bilateral inguinal hernia operation 2-6-62

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED Feb 10-62

ACTUAL SIGNATURE Frank J. Brochart M.D. EXAMINER'S (Type) Frank J. Brochart
Address (Street, city, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-12-62 22c. NAME OF CEMETERY OR CREMATORY Laytonsville 22d. LOCATION (City, town, or country) (State) Laytonsville, Maryland

23. FUNERAL DIRECTOR Francis X. Barber ADDRESS Laytonsville, Md.
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
DATE FEB 14 '62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

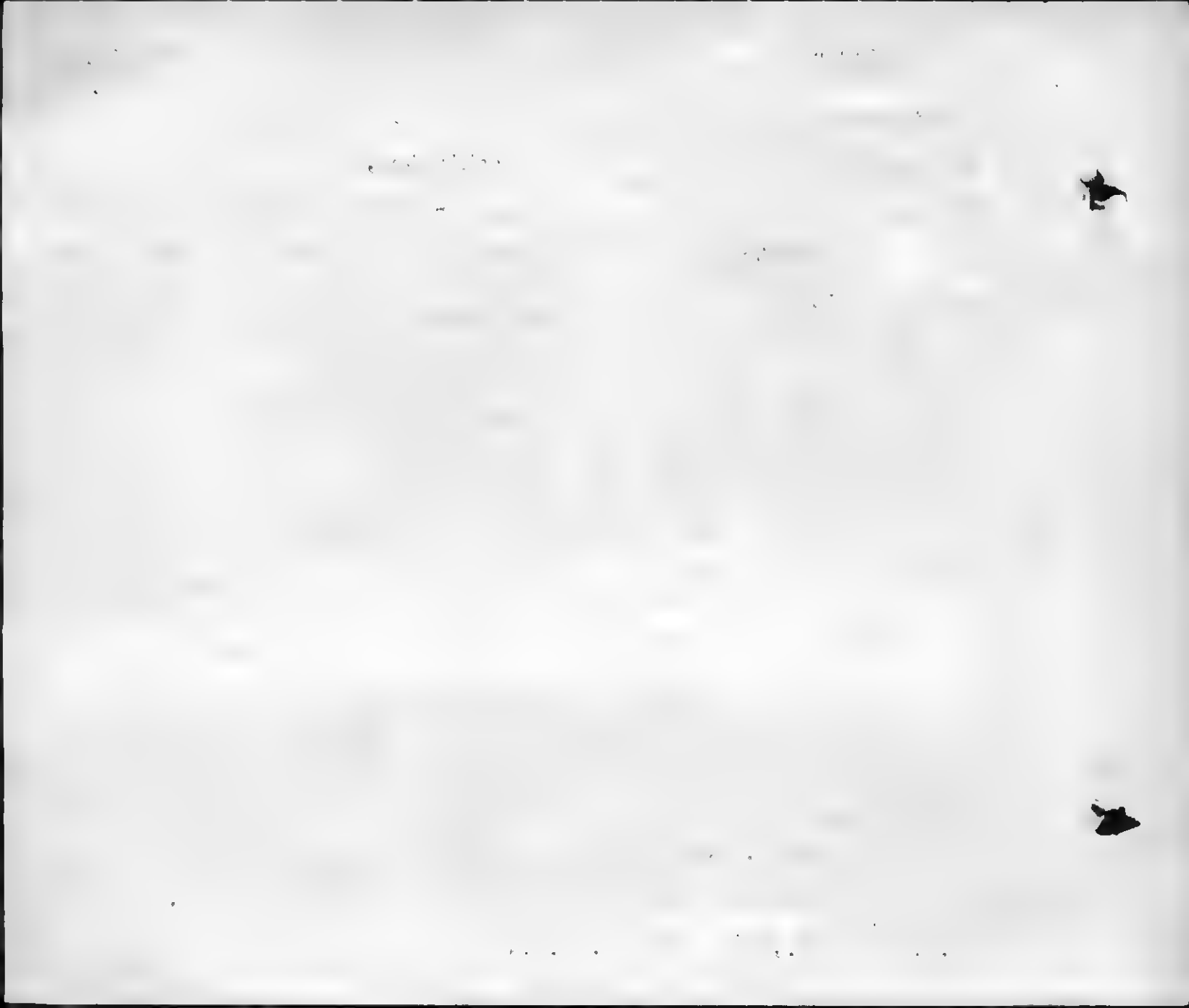
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02178

CERTIFICATE OF DEATH

02161

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Suburban	
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY --		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC	
d. STREET ADDRESS 4500-Newark Street NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edythe		First Middle Last Weed		4. DATE OF DEATH Month Day Year Feb 21 19 62	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 16 1882		9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hemlock Grove Ohio U.S.A.	
13. FATHER'S NAME David M. Nelson		14. MOTHER'S MAIDEN NAME Marcella C. Shumway		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT E. R. Nelson Address 3121-16th St NW.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Coronary Thrombosis (c) Arteriosclerosis Heart Disease Diabetes Mellitus - Gen. Arteriosclerosis 2 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Duodenal Ulcer, Chr. Pyelonephritis (Prev 455)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Nephrectomy		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 - 6 , 19 62 to Feb 21 , 19 62 ; that (I) (we) last saw the deceased alive on Feb 20 , 19 62 , and that death occurred at 11 M, from the causes and on the date stated above.					
22a. SIGNATURE James E. Nolan		22b. DATE SIGNED 2-21-62		22c. PHYSICIAN'S NAME (Type) James E. Nolan	
22d. ADDRESS 5401 Western Ave NW Wash DC.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/24/62		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
23d. LOCATION (City, town or county) (State) Washington, D.C.		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.,		24a. ADDRESS Wash, DC		24b. REC'D BY REGISTRAR DATE FEB 23 '62	
24c. REGISTRAR'S SIGNATURE ...		24d. REGISTRAR'S SIGNATURE ...		24e. REGISTRAR'S SIGNATURE ...	



CERTIFICATE OF DEATH

Reg. Dist. No. 02162

02179

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10102 KINROSS AVENUE		d. STREET ADDRESS 10102 KINROSS AVENUE	
3. NAME OF DECEASED (Type or print) ELIZABETH MURCHY WEIR		4. DATE OF DEATH FEBRUARY 7 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 24, 1880
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) SCOTLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HYSLOP		14. MOTHER'S MAIDEN NAME ELIZABETH IRVING IRVINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO NONE	
17. INFORMANT DAUGHTER Address MARGARET WARE - 10102 KINROSS AVE SE, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMATOSIS 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA RIGHT BREAST DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE			INTERVAL BETWEEN ONSET AND DEATH 22 Mo 20 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-25 1961 , to 2-7-1962 , that I last saw the deceased alive on 2-6-1962 , and that death occurred at 1:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2-7-62 DATE SIGNED Samuel A. Hillman M.D. 8829 Flower Ave. Silver Spring PHYSICIAN'S NAME (Type) SAMUEL A. Hillman MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-10-62	22c. NAME OF CEMETERY OR CREMATORY Mt. Wollaston Cemetery	22d. LOCATION (City, town, or county) (State) Quincy Norfolk Co., Massachusetts
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc. ADDRESS 8843 Georgia Avenue Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE FEB 9 '62	24b. REGISTRAR'S SIGNATURE C. J. R. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

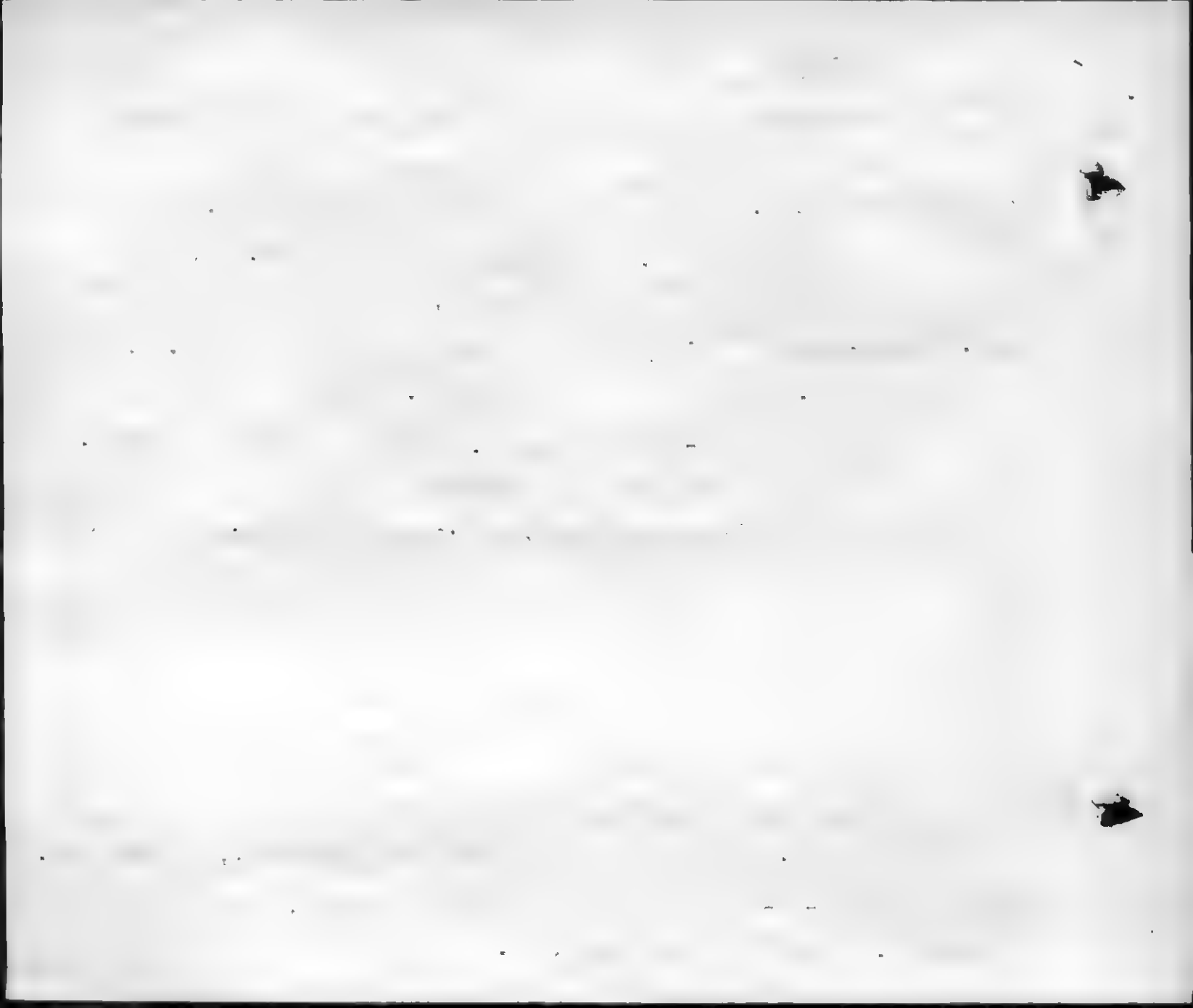
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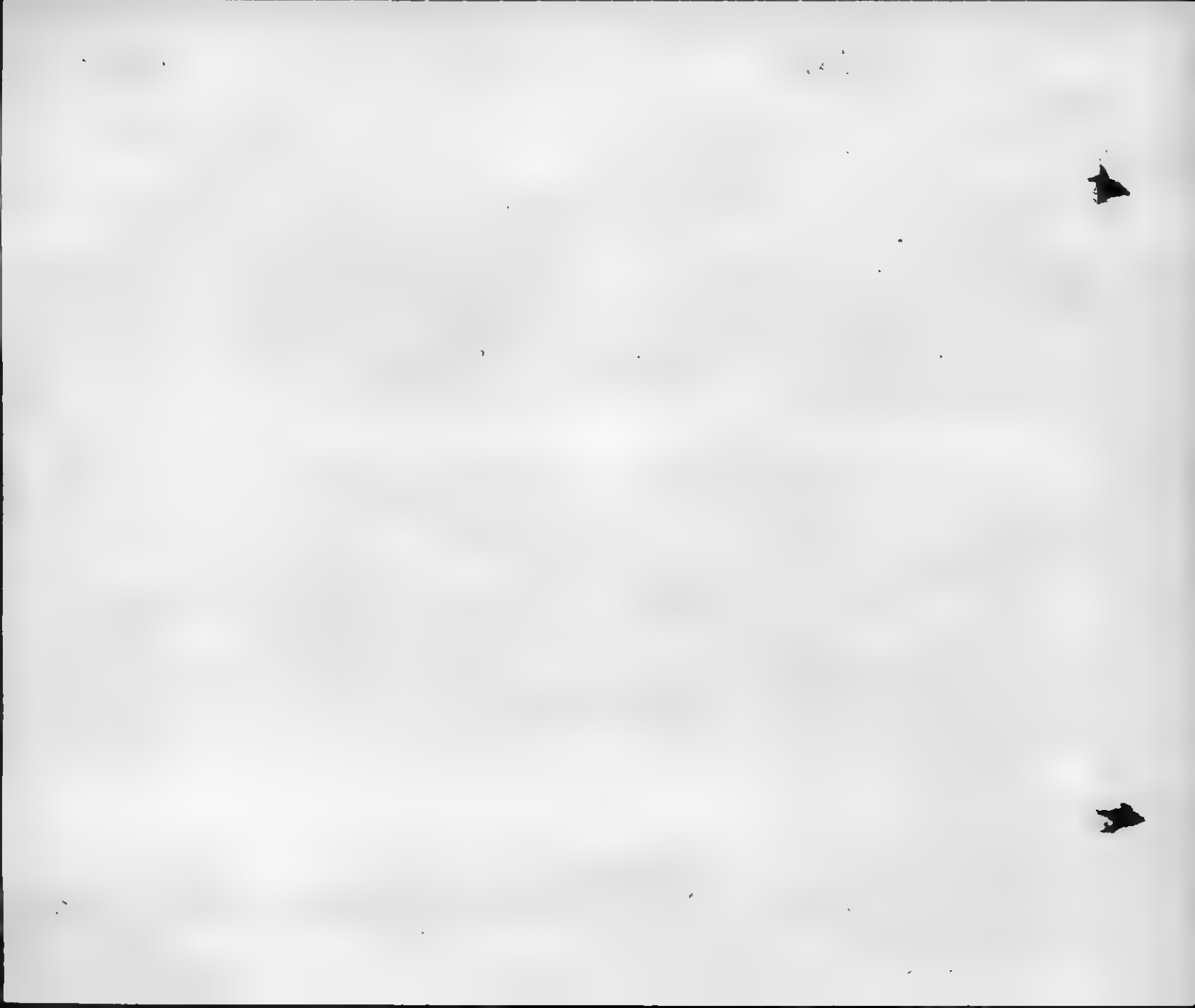
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02180

02163

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7611 Whittier Blvd.		d. STREET ADDRESS 7611 Whittier Blvd.	
3. NAME OF DECEASED (Type or print) ROBERT A. WELLS		4. DATE OF DEATH Feb. 22, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH June 19, 1905	
15a. CHIEF OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Info. Officer, Fish & Wildlife Service, Gov't		11. BIRTHPLACE (County & State, or foreign country) New York	
13. FATHER'S NAME Stewart G. Wells		14. MOTHER'S MAIDEN NAME Ida B. Starrin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 075-07-6216	
17. INFORMANT Wife		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION + 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY ARTERY DISEASE WITH ANGINA		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 2 MC.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8218 Wisconsin Ave., Bethesda, Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT. 1957 to FEB. 22, 1962 that (I) (we) last saw the deceased alive on FEB. 19, 1962 and that death occurred at 3:30 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 2/22/62	
22a. SIGNATURE Leo M. Curtis		22c. PHYSICIAN'S NAME (Type) LEO M. CURTIS	
22d. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial-transit 2-25-62		23b. DATE THEREOF 2-25-62	
23c. NAME OF CEMETERY OR CREMATORY Bethlehem Cemetery		23d. LOCATION (City, town or county) (State) Delmar, New York	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR DATE MAR 1 '62		25b. REGISTRAR'S SIGNATURE Robert S. Kline	





CERTIFICATE OF DEATH

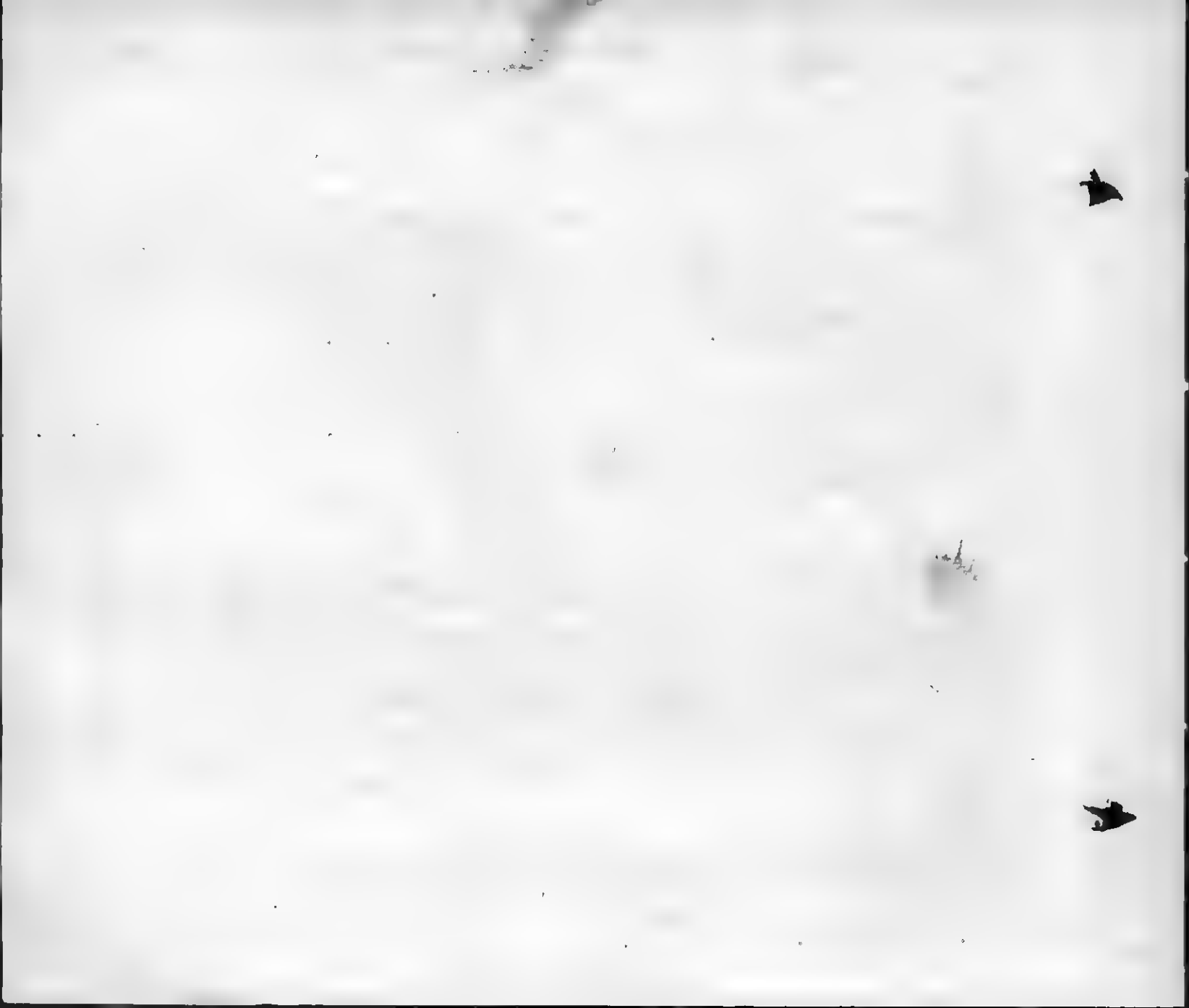
Reg. Dist. No. 02165

02182

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9406 Garwood Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor HARVEY Whitcroft</u>		4. DATE OF DEATH Month Day Year <u>February 5th, 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11th, 1905</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Procurement Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. School Board</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Walter Harvey</u>	
14. MOTHER'S MAIDEN NAME <u>Eleanor Bagger</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, of unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT Address <u>Richard P. Whitcroft, 9406 Garwood St. Sil.Sp.Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of both breasts with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>February 1961</u> to <u>February 5, 1962</u> , that I last saw the deceased alive on <u>February 5, 1962</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>9301 Colesville Rd., Silver Spring Md. Feb. 5, 1962</u>	
PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		<u>9301 Colesville Rd., Silver Spring, Md. Feb. 5, 1962</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/8/1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.L. Chambers, Inc. Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Linnet S. Fink</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

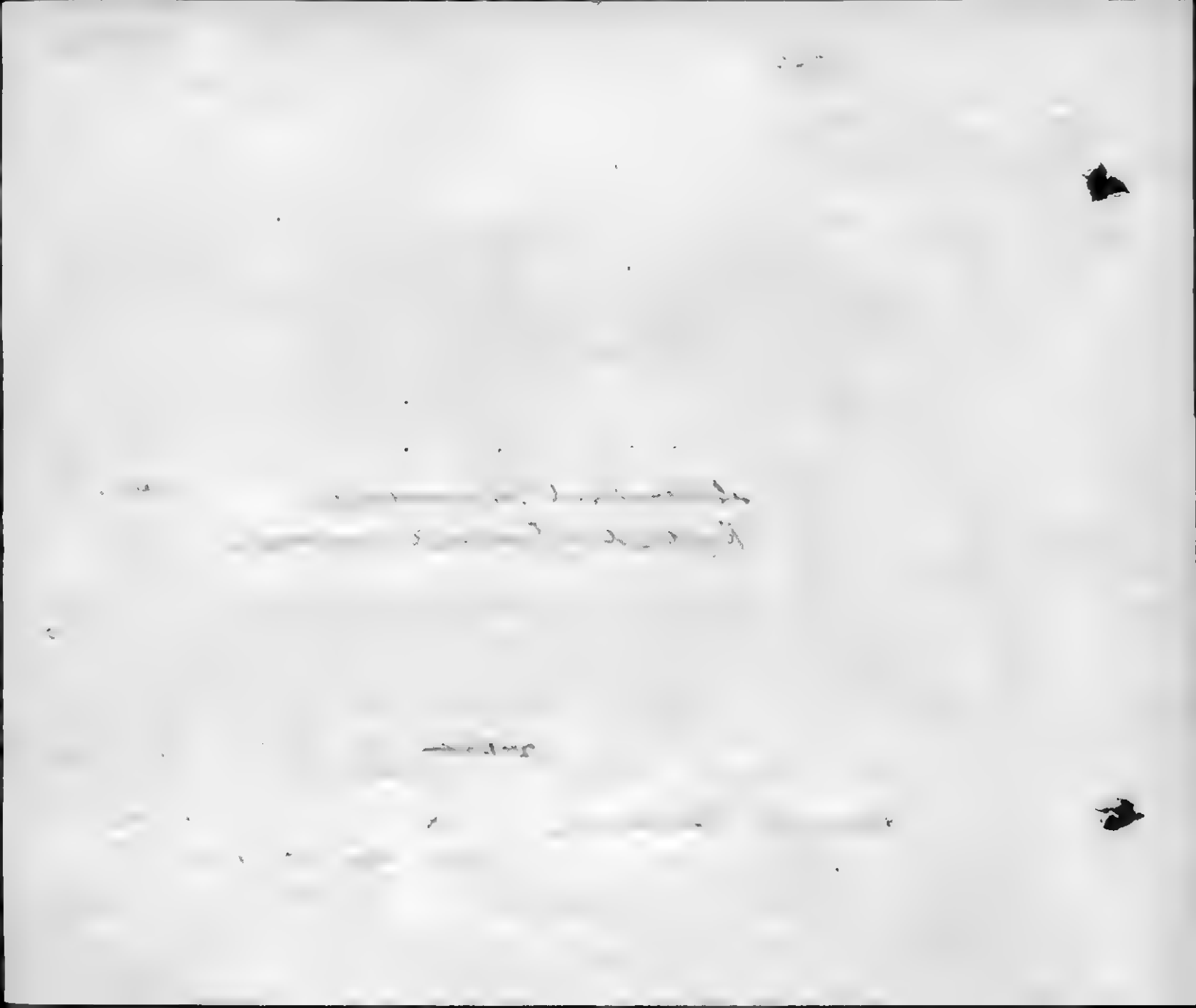
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. P. Broderick Notified

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
02183 CERTIFICATE OF DEATH 02186																	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>8 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>116 Rolling Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>L.</u> Last <u>White</u>						4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1962</u>											
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/13/17</u>						9. AGE (In years) IF UNDER 1 YEAR: <u>44</u> yrs. IF UNDER 24 HRS.: <u>44</u> yrs. Months <u>44</u> Days <u>44</u> Hours <u>44</u> Min. <u>44</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <u>Mailman</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>US Post Office</u>						11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Rodney White</u>						14. MOTHER'S MAIDEN NAME <u>Mary E. Walker</u>						Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>						16. SOCIAL SECURITY NO. <u>220-09-9528</u>						17. INFORMANT <u>wife, Kate H. White</u>		Address <u>same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>subarachnoid hemorrhage</u> DUE TO (b) <u>Ruptured intracranial aneurysm</u> DUE TO (c) <u>14 hours</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>14 hours</u>												INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Yes</u>						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)											
20c. TIME OF INJURY Month, Day, Year <u>1962</u> Hour a.m. <u>9</u> p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2-13-62</u> to <u>2-13-62</u> , 19 <u>62</u> , that (I) <u>last</u> saw the deceased alive on <u>2-13-62</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>Harvey H. Ammerman</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2-13-62</u>											
22c. PHYSICIAN'S NAME (Type) <u>Dr. Harvey Ammerman</u>						22d. ADDRESS <u>2025 Eye St. N.W., D.C.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>Feb 17/62</u>						23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>					
23d. LOCATION (City, town or county) <u>Gaithersburg</u>						23e. (State) <u>MD</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund C. Gertner</u>						ADDRESS <u>Gaithersburg</u>						25a. REC'D BY REGISTRAR <u>FEB 16 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Clifford S. ...</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

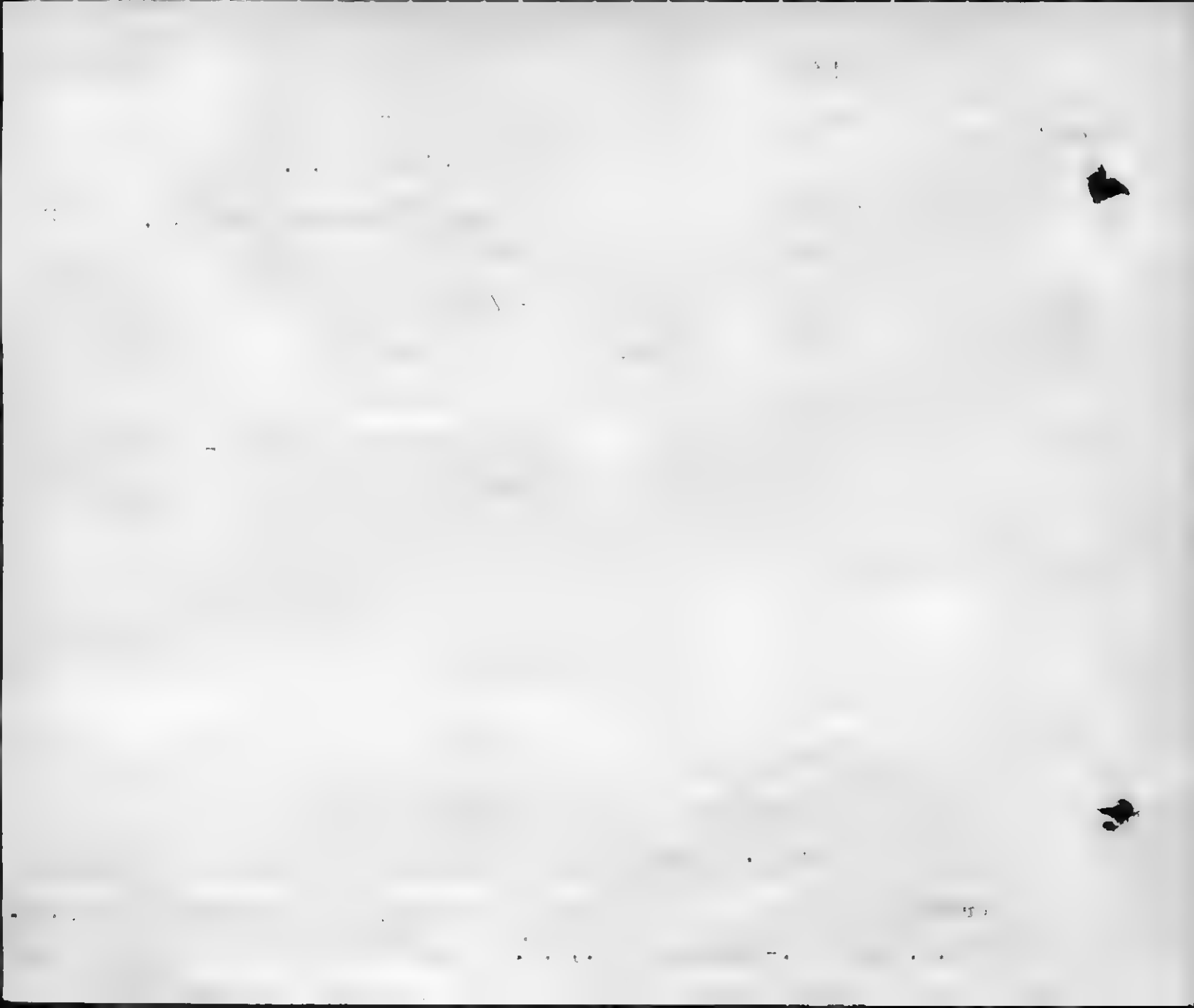
02184

02167

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE -- b. COUNTY --		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		
c. LENGTH OF STAY in 1b 1000 Daleview Drive			d. STREET ADDRESS 1753 Kilbourne Place, N.W.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Althea Woodland of Silver Spring			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOSEPHINE			4. DATE OF DEATH WHITE 12/7/1873 20 19 62		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/7/1873		9. AGE (In years last birthday) 88 IF UNDER 1 YEAR: Months 8 Days 8 IF UNDER 24 HRS.: Hours 8 Min. 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (County & State, or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE WHITE		14. MOTHER'S MAIDEN NAME KATHRYN LOWE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Records at Nursing Home -- Same #1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO (b) 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 332X					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). uremia. Arteriosclerotic heart disease					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 21 July, 1960 to 20 July, 1962 ; that (I) (we) last saw the deceased alive on 19 July, 1962 , and that death occurred at 2 AM , from the causes and on the date stated above.					
22a. SIGNATURE Seruch T. Kimble		22b. DATE SIGNED 21 July 1962		22c. PHYSICIAN'S NAME (Type) Seruch T. Kimble	
22d. ADDRESS 927 Pershing Drive, Silver Spring, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Crementation		23b. DATE THEREOF 2/22/62		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory Prince Georges County, Md.	
23d. LOCATION (City, town or county) Wash. DC		23e. REC'D BY REGISTRAR FEB 21 '62			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.		25. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02185

02168

1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		e. STREET ADDRESS SYKESVILLE	
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE LESLIE WILBURN		4. DATE OF DEATH Month Day Year FEBRUARY 10 1962	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-16-1983	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED R.R. CONDUCTOR		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA	
13. FATHER'S NAME WILLIAM WILBURN		14. MOTHER'S MAIDEN NAME MARY MARTHA BUCKALEW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) ACUTE GENERALIZED PERITONITIS DUE TO PERFORATED ULCERATED CARCINOMA OF STOMACH CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (e), STATING THE UNDERLYING CAUSE LAST. DUE TO OF STOMACH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 20, 1961 to 2.10.1962 that (I) (was) last saw the deceased alive on 2.8.1962 and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Sani Okutman		22b. DATE SIGNED 2.8.62	
22c. PHYSICIAN'S NAME (Type) A. SANI OKUTMAN, M. D.		22d. ADDRESS SYKESVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-13-62	
23c. NAME OF CEMETERY OR CREMATORY Trill Crest		23d. LOCATION (City, town or county) (State) SYKESVILLE, MD	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight		25a. REC'D BY REGISTRAR DATE FEB 15 '62	
25b. REGISTRAR'S SIGNATURE Arthur H. Haight			

RETIRED R.R. CONDUCTOR
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MONTGOMERY STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02186
02189
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11507 Georgia Avenue</u>															
3. NAME OF DECEASED (Type or print) <u>Wilhelm</u>		4. DATE OF DEATH <u>February 18, 1962</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>2-18-62</u>		9. AGE (In years last birthday) yrs. <u>20</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>no</u>	
13. FATHER'S NAME <u>Sonny Gene Wilhelm</u>				14. MOTHER'S MAIDEN NAME <u>Helen Effie Price</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>father</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 762-5 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>asphyxia</u> (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from....., 19.., to....., 19...., that (I) (we) last saw the deceased alive on....., 19...., and that death occurred at.....M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>Herbert J. Friedel</u>				22b. DATE SIGNED <u>2/20/62</u>				22c. PHYSICIAN'S NAME (Type) <u>Herbert J. Friedel, M. D.</u>				22d. ADDRESS <u>6826 Riggs Rd., Hyattsville, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>2-19-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital</u>				23d. LOCATION (City, town or county) (State) <u>Takoma Park, Maryland</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Wash. San. & Hospital</u>				25a. REC'D BY REGISTRAR <u>1 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Robert A. Hare</u>				25c. REGISTRAR'S SIGNATURE							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02187

CERTIFICATE OF DEATH

02170

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Rest Home		d. STREET ADDRESS 3825 Hamilton Street	
3. NAME OF DECEASED (Type or print) SUSIE		4. DATE OF DEATH Month Feb. Day 25 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1878
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England	
13. FATHER'S NAME Anthony Wilkinson		14. MOTHER'S MAIDEN NAME Sarah Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 579-24-6939 INFORMANT Anthony Wilkinson Same as #2 (nephew) Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 4 IMMEDIATE CAUSE (a) HYPERTENSIVE HEART DISEASE ESSENTIAL HYPERTENSION GENERALIZED ARTERIOSCLEROSIS DUE TO (b) SENILITY DUE TO (c) SENILITY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour 19 a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT. 22, 1961 , to Feb. 25, 1962 that (I) (we) last saw the deceased alive on Feb. 25, 1962 and that death occurred at 5 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Francis Gasch		22b. DATE SIGNED Feb. 25-1962	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/28/62	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR MAR 1 '62	
ADDRESS Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE Robert S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02188

02171

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 43 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY District Of Columbia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 651 Jefferson Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie Elizabeth Williams First Middle Last		4. DATE OF DEATH February 13, 1962 Month Day Year		9. AGE (in years last birthday) 33 yrs. If UNDER 1 YEAR: Months Days Hours M.n. If UNDER 24 HRS.: M.n.	
5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 26, 1928		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bacteriologist 10b. KIND OF BUSINESS OR INDUSTRY Laboratory 11. BIRTHPLACE (Country & State, or foreign country) Ohio 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Tinley		14. MOTHER'S MAIDEN NAME Alma Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unascertainable 17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter on y one cause; or r for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypotension and cerebral ischemia (b) Cancer of the right breast (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 year			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 1, 1962 to February 13, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 13, 1962 , and that death occurred at 1:30 AM from the causes and on the date stated above.					
22a. SIGNATURE <i>Richard S. Rivlin</i>		22b. PHYSICIAN'S NAME (Type) Richard S. Rivlin		22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> February 13, 1962 22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-18-62		23c. NAME OF CEMETERY OR CREMATORY NAT'L. CEM. ARLINGTON, VIRGINIA 23d. LOCATION (City, town or county) ARLINGTON, N.W. 23e. REC'D BY REGISTRAR FEB 15 '62 23f. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>	

WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02189
CERTIFICATE OF DEATH
02172

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 31 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 802 North Wayne St., Apt. 103	
3. NAME OF DECEASED (Type or print) Catherine Mable Williams First Middle Last		4. DATE OF DEATH February 4, 1962 Month Day Year	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1920 Month Day Year	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office manager		9b. AGE (In years, if UNDER 1 YEAR, last birthday) 41 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office manager		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTH PLACE (Country & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Finis Williams		14. MOTHER'S MAIDEN NAME Emmajoe Payton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-16-2918	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia due to E. Coli and renal failure DUE TO (c) Acute Myelogenous Leukemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH 8. NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 11 days 6 months			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 4, 1962 to February 4, 1962 , that 10 (we) last saw the deceased alive on February 4, 1962 , and that death occurred at 9:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert H. Levin</i>		22b. DATE SIGNED February 5, 1962	
22c. PHYSICIAN'S NAME (Type) Robert H. Levin		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 2/6/62		23b. DATE THEREOF 2/6/62	
23c. NAME OF CEMETERY OR CREMATORY Fayette Cemetery		23d. LOCATION (City, town or county) (State) Fayette, Missouri	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REG. STRAR FEB 9 '62	
25b. REGISTRAR'S SIGNATURE <i>C. L. S. Thomas</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH

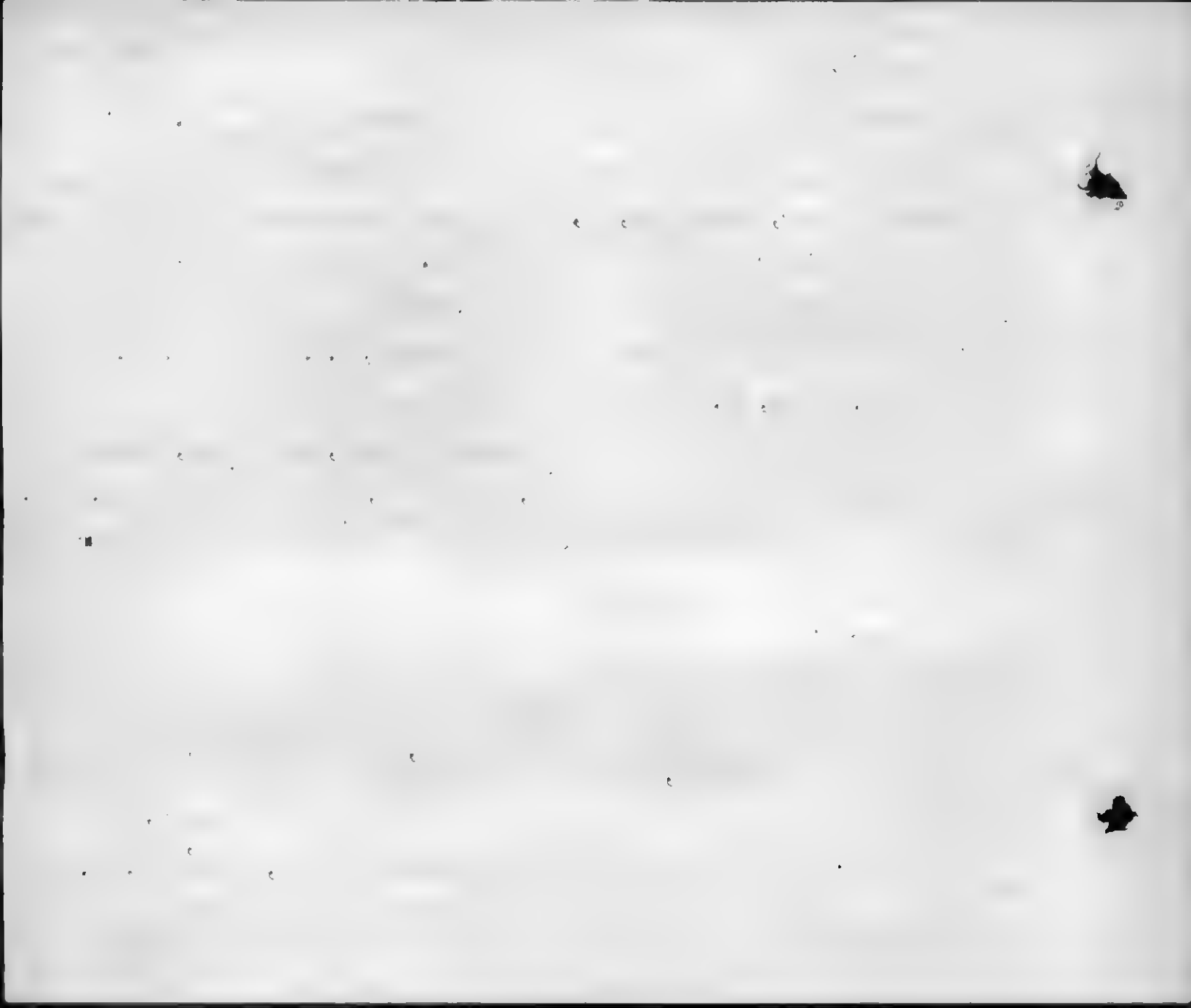
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02190

CERTIFICATE OF DEATH

02173

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN It <u>23 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u> d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) <u>Richard Lee Wilson Jr.</u>		4. DATE OF DEATH February 28, 1962	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 25, 1958</u>	9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.) <u>3</u> yrs. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (Country & State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard L. Wilson, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Rose Greenwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>involvement of liver, lymph nodes, and kidneys</u> DUE TO <u>necrotizing, hemorrhagic bronchopneumonia of</u> (b) <u>Right and left lungs</u> DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Ulceration, esophagus</u>	
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs. 4 mo. 12 hours</u>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 5, 1962</u> to <u>February 28, 1962</u> that (I) (we) last saw the deceased alive on <u>February 28, 1962</u> and that death occurred at <u>4:35 p.m.</u> from the causes and on the date stated above		22a. SIGNATURE <u>J. David Heywood</u> 22c. PHYSICIAN'S NAME (Type) <u>J. David Heywood</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-3-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST ALOYSIUS CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>LEONARDTOWN, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers Co</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 5 62</u>	
25b. REGISTRAR'S SIGNATURE <u>W W Chambers Co</u>		25c. DATE <u>MAR 5 62</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled out by the physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, P. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02191 Item 9 Film G306 2/9/62 1wk 02174											
1. PLACE OF DEATH											
a. COUNTY <u>Montgomery</u> MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> LENGTH OF STAY N 1b <u>15 days</u>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. l, give street address) <u>St. Elizabeth's</u>											
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Winner</u> Middle <u>Winn</u> Last <u>Winn</u>											
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAY-1879</u> 9. AGE (In years last birthday) <u>82</u> 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>gold letterer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired-private</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Ukraine</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Samuel L Winner</u> 14. MOTHER'S MAIDEN NAME <u>Martha Brodsky</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>DR. HARRY J. WINNER</u> Address <u>1819 COLTON RD ADOLPHI - MD.</u>											
18. CAUSE OF DEATH (Enter only one cause for line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4580</u> DUE TO <u>Generalized arteriosclerosis</u> (b) <u>4580</u> DUE TO <u>4580</u> (c) <u>4580</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>4580</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>1962</u> 20d. INJURY OCCURRED Whole et work <input type="checkbox"/> Not Whole et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> to <u>Feb 1</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Feb 1</u> , 19 <u>62</u> , and that death occurred at <u>9P</u> M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Abraham Danish</u> 22b. DATE SIGNED <u>2-2-62</u>											
22c. PHYSICIAN'S NAME (Type) <u>A Abraham Danish</u> 22d. ADDRESS <u>1106 Spring M S.S. Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2-4-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ABRAHAM CEM.</u> 23d. LOCATION (City, town or county) (State) <u>NEWARK - N.J.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Langansky & Son</u> ADDRESS <u>3501 14th St. W. Wash DC</u> 25. REGISTRAR'S SIGNATURE <u>William S. Kane</u>											



IN HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02192

02175

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>New York</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York</u> d. STREET ADDRESS <u>355 West 246th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Harold George Wolff</u>		4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1962</u>		9. AGE (In years, if UNDER 1 lost birthday) <u>64</u> yrs. Months <u>6</u> Days <u>19</u> Hours <u>62</u> M n.
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Lewis Wolff</u>		14. MOTHER'S MAIDEN NAME <u>Emma Weisslader</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY NO. <u>Unascertainable</u>		17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO (b) <u>OCCLUSION INTERNAL CAROTID ARTERY LEFT AND MIDDLE CEREBRAL RIGHT</u> DUE TO (c) <u>AND MIDDLE CEREBRAL RIGHT</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 14, 1962</u> to <u>February 21, 1962</u> , that <u>he</u> (we) last saw the deceased alive on <u>February 21, 1962</u> , and that death occurred at <u>9:58 PM</u> from the causes and on the date stated above.
22a. SIGNATURE <u>George Milton Shy</u>		22b. DATE SIGNED <u>22 Feb 62</u>		22c. PHYSICIAN'S NAME (Type) <u>George Milton Shy, M.D.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 24, 1962</u>		23b. DATE THEREOF <u>Feb 24, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westerly</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>FEB 26 62</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02193

02176

1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San. & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Wash. D.C. b. COUNTY _____
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) _____
d. STREET ADDRESS 1704 Morningside Dr.

3. NAME OF DECEASED (Type or print)
First HING Middle WONE Last WONG

4. DATE OF DEATH
Month 2 Day 12 Year 1962

5. SEX MALE **6. COLOR OR RACE** YELLOW **7. MARRIED** ☐ NEVER MARRIED ☐ **8. DATE OF BIRTH** 6-5-89 **9. AGE** (In years last birthday) 72 yrs. **IF UNDER 1 YEAR** Months _____ Days _____ **IF UNDER 24 HRS.** Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter **10b. KIND OF BUSINESS OR INDUSTRY** Restaurant **11. BIRTHPLACE** (County & State, or foreign country) China **12. CITIZEN OF WHAT COUNTRY?** AMER.

13. FATHER'S NAME _____ **14. MOTHER'S MAIDEN NAME** _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO **16. SOCIAL SECURITY NO.** _____ **17. INFORMANT** Hospital Records Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain tumor
DUE TO (b) Chronic Myocarditis
DUE TO (c) Uremia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER) **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.) _____

20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____ **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) _____ **20f. (City or town)** _____ (County) _____ (State) _____

21. I certify that (I) (this hospital) attended the deceased from 2/12/1962 **to** 2/12/1962 **that (I) (we) last saw the deceased alive on** 2/12/1962 **and that death occurred at** 2:30 PM **from the causes and on the date stated above.**

22a. SIGNATURE Howard T. Moore **22b. DATE SIGNED** _____
22c. PHYSICIAN'S NAME (Type) Howard T. Moore M.D. **22d. ADDRESS** _____

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial **23b. DATE THEREOF** 2-17-62 **23c. NAME OF CEMETERY OR CREMATORY** George Washington Cem **23d. LOCATION** (City, town or county) Hyattsville (State) _____

24. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee **25a. REC'D BY REGISTRAR** 1-14-62 **25b. REGISTRAR'S SIGNATURE** 1-14-62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02194

CERTIFICATE OF DEATH

02177

Item 9 Film G308 3/9/62 mh

1. PLACE OF DEATH a. COUNTY Montg MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland b. COUNTY Montg		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 20yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS 110 N. Diamond Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Benjamin Middle Owen Last Woodward			4. DATE OF DEATH Month Feb Day 27 Year 1962		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31-1871	9. AGE (In years last birthday) 90 1/2 yrs.	IF UNDER 1 YEAR Months 6 Days 20 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME Roszel Woodward		
14. MOTHER'S MAIDEN NAME Eliza J. Reid			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Corrie V. Woodward. Gaithersburg. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis. 4-20-0 DUE TO (b) Artherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2/27/62	
20f. (City or town) (County) (State) 		21. I certify that (I) (his hospital) attended the deceased from 1958 to 2/27 , 19 62 , that (I) (we) last saw the deceased alive on 2/17 , 19 62 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Luciano I. Leal		22b. DATE SIGNED 		22c. PHYSICIAN'S NAME (Type) Luciano I. Leal	
22d. ADDRESS Gaithersburg, Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-2-62		23c. NAME OF CEMETERY OR CREMATORY Forest Oak	
23d. LOCATION (City, town or county) Gaithersburg		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg Md.		24b. ADDRESS 		25a. REC'D BY REGISTRAR MAR 6 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline					

75130

48190

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02195

02178

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 22 days		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MD.		b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		d. STREET ADDRESS 6216 WOODWARD RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) J. BRUCE		First		Middle		Last WRIGHT		4. DATE OF DEATH FEB.		Month 21		Day 1962		Year	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 24, 1877		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.									
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Yes-Unknown		17. INFORMANT A. Bruce Wright - 6216 Woodward Rd. Bethesda, Md.		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive and Coronary atherosclerotic Heart Disease DUE TO cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mo.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF DEATH Month, Day, Year Hour a.m. 10:30 AM p.m. 2/21/1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda		(County) Montgomery		(State) Md.					
21. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1962 to Feb. 21, 1962 , that (I) (we) last saw the deceased alive on Feb. 11, 1962 , and that death occurred at 10:30 AM , from the causes and on the date stated above.															
22a. SIGNATURE Frank S. Bacon		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 21, 1962									
22c. PHYSICIAN'S NAME (Type) Frank S. Bacon				22d. ADDRESS 1150 Conn. Ave. N. W., Wash. DC											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2/21/62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) Suitland, Maryland		(State) Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR FEB 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna									

05180

05180



Handwritten text, possibly a signature or address, including the words "Hypocrite" and "Cigarette".

Handwritten text at the bottom of the page, including the word "Hypocrite" and other illegible markings.